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Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO ONTARIO

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Monday,
the 3rd of October, 1960,
at 10.00 a.m.

COMMITTEE:

MR. H. L. ROWNTREE, Q.C. Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G. F. LAVERGNE

MR. S. J. GADSBY, F.C.I.S., Secretary



Monday,
October 3, 1960.

414

--- On resuming at 2:15 p.m.

THE CHAIRMAN: If we are ready to proceed, gentlemen, we will resume our inquiry.

Now this afternoon we are going to hear from Mr. Harold Smith of the Ontario Retail Pharmacy Association and before Mr. Smith starts, I would ask him to outline for us just the nature of his presentation, very briefly, before we get into it because I have some observations I wish to make, and I may make them before he starts his main presentation, or afterwards.

Mr. Smith would you tell us - are you here Mr. Smith?

MR. SMITH: Right here.

THE CHAIRMAN: Would you come forward, sir?

--- Mr. Harold Smith, Secretary-Treasurer and Business Manager of the Ontario Retail Pharmacists' Association comes forward.

THE CHAIRMAN: Before you commence, as I have indicated, what is the nature of your presentation today?

MR. SMITH: Mr. Chairman, gentlemen of the Committee, I prepared a very short paper, and it's really the preamble; states what our Association is, and what we are organized for. Would you want me to read that?

THE CHAIRMAN: How long is it?

MR. SMITH: The whole thing?



1

2

THE CHAIRMAN: Yes.

3

4

MR. SMITH: Oh, I can read it in 5 or 7 minutes.

5

6

MR. SUTTON: Is this the copy we already have?

7

MR. SMITH: Yes.

8

MR. SUTTON: We have already read it.

9

10

THE CHAIRMAN: Well now I suggest, Mr. Smith, that you proceed with this presentation and I will make my observations after you finish.

12

MR. SMITH: All right, Mr. Chairman.

13

14

Well Mr. Chairman, members of the Committee The Ontario Retail Pharmacists' Association was organized in 1918 as a voluntary association in which every retail Pharmacist in Ontario could become a member.

17

18

The objects of the Association as set forth in the constitution are:-

19

20

To advance the scientific and professional aspects of Pharmacy

21

22

To promote the mutual rights and interests of retail pharmacists in Ontario, and

23

24

To develop methods and ideals in merchandising

25

26

27

There are approximately 2,043 Retail Pharmacies in Ontario of which 1,400 owners or managers paid the annual membership fee in O.R.P.A. for the year 1960.

28

29

30

Our members are subject to the regulations of federal and provincial laws governing Pharmacy, the



1
2 the Pure Food & Drugs Act, the Opium and Narcotic
3 Act, and many municipal by-laws and regulations which
4 have been enacted to protect the public health, as well
5 as the Pharmacy Act.

6 Our membership represents the neighborhood
7 Pharmacist who, we feel, is most useful to consumers
8 in his district through convenient availability of
9 goods and through actual services rendered. As a
10 distributor he must, of course, have a fair margin of
11 profit on his sales to carry his overhead and cover
12 the services he renders. We believe our members are
13 continually studying ways and means of distributing the
14 items they carry in stock efficiently and economically
15 in order to retain sufficient consumer patronage and
16 to remain in business.

17 It is a common principle that retail
18 Pharmacists purchase the best products possible at the
19 best price that can be obtained, and sell them to their
20 customers at a reasonable mark-up that will yield the
21 cost of operation and net profit.

22 It should be established that as it is the
23 professional responsibility of the medical doctor to
24 diagnose an ailment and prescribe the corrective
25 treatment, it is the legal and professional responsibility
26 of the pharmacist to dispense the proper medication
27 and the correct dosage to the patient. These res-
28 ponsibilities plus a self-imposed code of ethics make
29 it such that the pharmacist cannot consider a doctor's
30



1
2 prescription as an object of commerce. He must regard
3 it as a specific order given by an authorized person
4 to supply medication in a specified form and dosage
5 for the treatment of a particular ailment. The
6 physicians alone can say which drugs they will use, and
7 pharmacists are bound to dispense what is prescribed.
8 To induce physician or patient to use cheaper drugs is
9 not the prerogative of the pharmacist.

10 No one denies that some drugs are costly but
11 this is because they are costly to discover and bring
12 into production. I have three examples there, Mr.
13 Chairman. I don't know whether you want me to read
14 them or not.

15 THE CHAIRMAN: Yes, just read it in.

16 MR. SMITH: All right. I use these three
17 as examples, and naturally I have taken them from other
18 authorities rather than material I have produced myself.

19 When cortisone was first synthesized, its
20 scarcity and incredibly difficult production process made
21 it extremely expensive. It was sold for \$200 a gram.
22 But within a short time a new process was developed
23 enabling chemists to produce large quantities at lower
24 costs. Even before there was any real competition in
25 the marketing of drugs its price has been reduced 90%.
26 By 1957, under the impact of competition, the price had
27 declined 99% and cortisone sold for \$2.00 per gram.

28 Penicillin is another good example. Between
29 1943 and 1950 its price dropped from \$20.00 per
30



1
2 100,000 unit to 4.5¢ at the factory. Streptomycin
3 which once cost about \$25.00 per gram now costs about
4 50 cents.

5 When Insulin was first made available the
6 average daily dose for a diabetic cost \$2.13. The
7 cost today is 12.4 cents daily. There are, of course,
8 many more examples.

9 In recent years research in pharmaceuticals
10 has gone on at an accelerated rate, and has put at the
11 disposal of physicians and patients, new potent
12 specific medication which has revolutionized therapy
13 as well as the practice of pharmacy. To reasonably
14 stock a prescription department today requires the
15 outlay of thousands of dollars. In many cases the
16 pharmacist subsidizes his prescription department with
17 the profits derived from the sale of items in the front
18 shop such as household remedies, patent medicines,
19 cosmetics and sundries.

20 In the matter of what drugs he dispenses the
21 pharmacist has to place his trust in firms of size and
22 reputation whose products he can be sure of. He will
23 not dispense the products of firms whose reputation is
24 unknown or in question even though the product may be
25 cheap in price. He would want to know whether the
26 drugs offered at low prices, whether generic, chemical,
27 common name or trade name, are exactly as represented
28 and whether their makers are reputable.

29 Along this line, I have taken a quotation
30 from the Honourable J. W. Monteith, Minister of



1
2 National Health & Welfare, in answer to a question in
3 the House of Commons February 10, 1960 in which he said
4 "My department has never claimed that it did analyze
5 every batch of every drug imported into this country,
6 and the staff and laboratory facilities for this would
7 have to be tremendous. Reputable manufacturers have
8 their own control facilities, but we also seek to
9 protect the consumer by making frequent spot checks on
10 drug shipments and by investigating particular imports
11 when this is felt desirable. The Directorate keeps
12 aware of developments in drug production in other
13 countries, and through arrangements with customs
14 officials is informed of all shipments of drugs."
15 That is the end of his statement.

16 I have a little item there on counterfeit
17 drugs which has come to our notice recently here in
18 Canada.

19 Counterfeit drug products are something else
20 that has to be watched. They are produced to resemble
21 in size, shape, colour and general appearance an
22 established, well known preparation. The great expense
23 of research, high quality production, advertising,
24 promotion and so forth is not involved in its sale.
25 It is often usually sold as a generic name item.

26 What has all the appearance of a big drug
27 counterfeiting operation was uncovered last June by a
28 raid on a loft warehouse in Hoboken, N.J.. The raid
29 turned up a large quantity of drugs, along with tablet-,
30



1
2 stamping dies bearing names or insignias of major drug
3 companies. The police also uncovered a long list of
4 invoices of firms to which sizeable shipment have been
5 made. The names of several Canadian companies were in
6 the list. Police are said to have found counterfeits
7 for Equanil, Miltown, Hydrodiuril, Esidrix, Meticorten
8 and Dexedrine.

9 The pharmacist is greatly concerned that all
10 drugs intended for the use of the public, whether
11 imported or manufactured in Canada, be subjected to a
12 controlled assay as to labelled potency and purity of
13 ingredients, and that no imported or Canadian manufac-
14 tured drugs be released for sale to the public until
15 this control procedure has been complied with.

16 I didn't introduce myself. It is signed
17 by myself, Secretary-Treasurer and Business Manager
18 of Ontario Retail Pharmacists' Association.

19 THE CHAIRMAN: Mr. Smith, I think that this
20 would be an opportune time for me to make some
21 observations, and if you care to sit down, I will
22 proceed.

23 Is Dr. White, the President of the Ontario
24 Dental Association present?

25 (No reply)

26 THE CHAIRMAN: Is any officer of the Ontario
27 Dental Association present?

28 (No reply)

29 THE CHAIRMAN: Is any official of the
30



1
2 Canadian Dental Association present?

3 (No reply)

4 THE CHAIRMAN: Are any members of the
5 Ontario Retail Pharmacists' present?

6 (Five members)

7 THE CHAIRMAN: Gentlemen, are you members
8 of the association or officers?

9 (One officer)- information officer)

10 THE CHAIRMAN: The officer is Mr. -?

11 MR. WILSON: Mr. Wilson.

12 THE CHAIRMAN: Your first name?

13 MR. WILSON: Carl.

14 THE CHAIRMAN: And your position?

15 MR. WILSON: President.

16 THE CHAIRMAN: President of the Ontario
17 Retail Pharmacists' Association?

18 MR. WILSON: Correct.

19 THE CHAIRMAN: And the information officer
20 is - ? Mr. Donald Crossley.

21 And the other gentlemen are members of that
22 association. Are any representatives of the R.H.O.K.E.A.
23 Association present?

24 (No reply)

25 THE CHAIRMAN: Are any members of the
26 Toronto Retail Druggists Association present? Some
27 of the same gentlemen. Are any officers of the Toronto
28 Retail Druggists Association present? Are any officers
29 of the National Body of Retail Druggists present?

30 (Page 423 follows)



1 MR. TURNBULL: There is not a national body of
2 retail pharmacists. The Canadian Pharmaceutical
3 Association --

4 THE CHAIRMAN: You are?

5 MR. TURNBULL: Mr. Turnbull.

6 THE CHAIRMAN: We had a brief discussion last
7 Friday when we were trying to identify the position
8 that Association bears to the other organizations.
9 In the light of our remarks last Friday, Mr. Turnbull,
10 are you able to add anything that would assist the
11 Committee by way of identification?

12 MR. TURNBULL: Along what line?

13 THE CHAIRMAN: To these organizations.

14 MR. TURNBULL: Oh, yes. You want the various
15 organizations listed, Mr. Chairman?

16 THE CHAIRMAN: No, I want you to tell us
17 if you can what body speaks as the authoratative voice
18 for the retail druggist.

19 MR. TURNBULL: In Ontario? The Ontario
20 Retail Pharmacists' Association speak on behalf of
21 the owners and managers of retail pharmacies.

22 THE CHAIRMAN: What position does the
23 R.H.O.K.E.A. organization have?

24 MR. TURNBULL: R.H.O.K.E.A. is a voluntary
25 organization of Jewish Pharmacists, particularly
26 in the Toronto area.

27 THE CHAIRMAN: R.H.O.K.E.A. is not entirely
28 a social organization? It has a business objective?

29 MR. TURNBULL: Oh yes, certainly. It has
30 on a local level objectives similar to that of the



1 O.R.P.A., Ontario Retail Pharmacists' Association,
2 on the provincial level, and it is similar to the
3 Toronto Retail Pharmacists' Association, which
4 embraces voluntarily all retail pharmacists in the
5 Toronto area.

6 THE CHAIRMAN: Thank you, Mr. Turnbull.
7 I appreciate your help in trying to clarify this
8 matter.

9 Mr. Wilson, will you come forward, sir?
10 The Ontario Retail Pharmacists' Association, might
11 it be described as the voice of the retail druggists
12 in Ontario?

13 MR. WILSON: I think, Mr. Chairman, that
14 would be correct.

15 THE CHAIRMAN: Would it be convenient for
16 you to file with the Secretary a list of the officers
17 of that Association?

18 MR. WILSON: Yes, the Secretary -- you
19 mean your Secretary?

20 THE CHAIRMAN: Yes.

21 MR. WILSON: Our Secretary has them, and
22 he can supply that list.

23 THE CHAIRMAN: You will instruct him on that?
24 Thank you. How many members have you got? That
25 is outlined in this brief that Mr. Harold Smith read
26 a little while ago. Are there any other organizations,
27 provincial in nature, besides your own?

28 MR. WILSON: Not of our nature, no. The
29 Ontario College of Pharmacy, of course, is provincial,
30 but it is a licensing body, and I believe ours is



1 considered more in the light of a merchandizing
2 body.

3 THE CHAIRMAN: Well, thank you, Mr. Wilson.

4 -----

5 THE CHAIRMAN: I think it should be stated
6 at this point to the public that this Committee has
7 some concern with respect to the response to its
8 inquiry which it has received from some sources of
9 the public which should be directly concerned with
10 these proceedings.

11 I want to digress for a moment and ask
12 the Secretary if he will report to the Committee
13 on his contacts with the Ontario Dental Association.

14 Is Mrs. Durham here?

15 MRS. DURHAM: Yes.

16 THE CHAIRMAN: Mr. Gadsby?

17 THE SECRETARY: For some time we made phone
18 calls endeavouring to get appearances, but apparently
19 the Chairman of the Dental Association is a practising
20 dentist, and he says that his calendar is pretty
21 full, and he has not been able to attend. Recently
22 he left to attend a convention, and it was then that
23 I wrote a letter asking him if he would appear
24 before us on the fourth.

25 I understand that he is back from the
26 convention, and he did pick up a flu germ. However,
27 he is in his office to-day, and he has assured me he
28 will endeavour to be here tomorrow.

29 Prior to his going to the convention, I
30 called him by phone and asked him if he would call



1 me back as to what date he might appear. However,
2 he neglected to do that. That is the reason we
3 found it necessary to write to him, and to-day on
4 the phone I asked Mrs. Durham if she would appear
5 for the Association so that she may take back whatever
6 information we have to put out to-day.

7 THE CHAIRMAN: Mrs. Durham, will you come
8 forward and take a seat at the front, please? Are
9 there any of your officers present with you to-day?

10 MRS. DURHAM: No, there are not.

11 THE CHAIRMAN: Are there any members of
12 your Association present?

13 MRS. DURHAM: Not that I know of.

14 THE CHAIRMAN: Before this Committee
15 convened in June, in my capacity as Chairman, I
16 listed all of the bodies that I could think of and
17 which had been mentioned to me by other members of
18 the Committee, and I telephoned the Dental Association,
19 The Hospital Association, the Medical and so on.
20 I felt that that was part of my duty as Chairman
21 of this Committee to do that before the hearings
22 commenced.

23 I called Mrs. Durham, among other people,
24 in her capacity as Secretary of the Ontario Dental
25 Association. She referred me to Dr. White, the
26 President. Is he still the President, Mrs. Durham?

27 MRS. DURHAM: No, Dr. White is only the
28 President elect. He has never been President. He
29 will be President next year.

30 THE CHAIRMAN: What was his capacity in May



1 of this year?

2 MRS. DURHAM: He was President Elect and
3 Chairman of the Executive Committee.

4 THE CHAIRMAN: Chairman of the Executive
5 Committee? Following a meeting which the Dental
6 Association held, I received a letter which was
7 brief and to the point, and I am trying to find it.
8 I may have it here. Under date of June 10, over
9 the signature of Mrs. Durham, the Secretary. This
10 is the letter:

11 "Dear Mr. Rowntree:

12 Your letter of May 31, 1960 --"

13 May I again digress and say that I followed my
14 telephone conversation up with a letter, in which
15 I invited the Dental Association to appear, and
16 I think I will read my letter into the record. Under
17 date of May 31, 1960, to Mrs. Durham:

18 "Dear Mrs. Durham:

19 May I inform your Association through
20 you that the sittings of the Select
21 Committee On Drugs appointed at the
22 last session of the Legislature will
23 commence in Committee Room No. 1,
24 Queen's Park on Tuesday, June 14,
25 at 10:00 o'clock in the morning.

26 It is possible that your
27 Association would like to make a
28 statement at the outset of the
29 Hearings, outlining the position of
30 your membership with respect to the



1 use and prescription of drugs, having
2 in mind the cost factor. Yours very truly."

3 Now I go back, and I will read from Mrs. Durham's
4 letter of June 10:

5 "Dear Mr. Rowntree:

6 Your letter of May 31, 1960 was brought
7 before a meeting of the Executive
8 Committee of the Ontario Dental Association
9 on Thursday, June 9, 1960. The Committee
10 felt there is not sufficient information
11 available as to the extent to which drugs
12 are prescribed by dentists to make
13 a statement. Yours very truly."

14 The Committee then sat in June, and having
15 thought about this matter during the Summer, I
16 instructed the Secretary to again contact the
17 Association.

18 Will you take a direct message back to
19 your officers, Mrs. Durham, and will you instruct them
20 that it is not the desire or intention of this
21 Committee to get into the position of subpoenaing
22 witnesses, but any person who accepts office in an
23 organization representing a professional body
24 probably has an honour conferred on him in being
25 so appointed, but that honour also bears with it
26 certain responsibilities.

27 It is also the practice in this country,
28 to my knowledge, that Associations speak for the
29 group they represent. I will say this that your
30 Association to date does not represent the feeling



1 or the opinion of many of your members in your dis-
2 regard of this Committee.

3 This Committee, Mrs. Durham, is a branch
4 of the Government. This Committee is the Legislative
5 Assembly. This Committee is not a Royal Commission.
6 This is a Committee of the Government, and it is
7 not the intention of any of the eleven members of
8 this Committee to stand by and be told by a professional
9 group that it does not have enough information to
10 make a statement, and indeed, does not intend to
11 make a statement.

12 You may convey my views on behalf of the
13 Committee to your officers in the strongest terms
14 possible.

15 I would think that the Ontario Dental
16 Association and the dentists of Ontario would have
17 a very real interest in appearing before this
18 Committee as a matter of public interest, and in making
19 a contribution to the public welfare of this
20 Province, and indeed, of this country.

21 I would think also that there must be
22 some statistics available, and if they are not
23 available, that your organization is in a position to
24 procure them, having in mind the fact that some
25 of the most important drugs used come under the
26 heading of anaesthetics, and the dental profession
27 uses a specialist group of anaesthetics, namely
28 local anaesthetics involved in the blocking of
29 nerves; some of them being highly expensive on the
30 one hand, and others being highly dangerous, and



1 requiring extreme care in their use and application.

2 Now, if this information is not available
3 on a voluntary basis as to the extent and use of
4 drugs in the dental profession, Mrs. Durham, we
5 will secure the information ourselves, but our
6 investigation will probably not have the adjective
7 "painless" attached to it.

8 My remarks to-day stem from our reaction
9 to this matter of the failure of the dental profession
10 to come forward.

11 I think I should go further and say it
12 is the view of the Committee that this investigation
13 must of necessity go into the question of the
14 retail pharmacists in far greater detail than is
15 contained in the brief submitted this afternoon.

16 Tomorrow we are going to hear from Professor
17 Fuller dealing with the economics and profit and
18 loss aspect of retail drugstore operations. We know
19 that Professor Fuller prepares an annual analysis
20 of retail drugstore operations which is submitted,
21 and usually published in the Canadian Pharmaceutical
22 Journal, and my observations of course must be taken
23 in the light of the fact that we have not heard
24 Professor Fuller.

25 We of the Committee thought it should be
26 made very clear to the public and to these interested
27 parties that general statements will not deter
28 this Committee from its investigation. I would think
29 that the representatives of the retail druggists should
30 be preparing a very careful detailed submission for



1 this Committee. I am interested in some of
2 the contents of the submission that we have had today
3 and this committee will be interested in knowing, for
4 instances, I am referring to page 3 at the top:

5 "In many cases the pharmacist subsidizes his
6 prescription department with the profits derived
7 from the sale of items in the front shop such as
8 patent medicines, cosmetics and sundries."

9 Mr. Smith; let me tell you that I would say
10 the general rule is that every drug store in this
11 province sells cosmetics and such sundry items. Your
12 statement should be worded in the other direction
13 to the effect that with very rare exceptions all drug
14 stores sell cosmetics, sundries, etc. I point this
15 out to you because we want to know why and there
16 probably is a good reason why. Why do druggists
17 sell cosmetics? Why do they sell ice cream? Why
18 do they sell sandwiches and have a lunch counter?
19 There must be a reason and I can think of several
20 answers myself but it is not up to me to give the
21 answers to these questions. Surely you gentlemen are
22 in a position to come and give this committee an
23 explanation of why your merchandising policies require
24 an adventure into these other departments.

25 We think you people are concerned generally
26 with the problem of stocking many hundreds and hundreds
27 of items under various trade names which is a
28 financial and physical impossibility, or may be.
29 I do not know. Now, why do you not come and tell us
30 how you have to deal with all problems. There must be



1 an answer. I would think that retail druggists do
2 have working arrangements each with the other.

3 What I am saying, in substance, is this:
4 this committee will not be satisfied with the kind
5 of broad statement that we received today. I would
6 not be a gentleman and I would not be fair if I
7 did not say to you what I am saying right now. I
8 will go further and tell you that there is no need
9 to hide behind any bushel on any subject before this
10 committee because there is no facet of the whole
11 story of drug costs and the problems affecting drug
12 costs that has not been aired fully and completely
13 in the public press, leading magazines and before
14 government committees of other jurisdictions during
15 the last ten years. This committee wants this
16 problem dealt with factually and in a forthright
17 manner. We are somewhat disappointed at the response
18 or the attitude taken by certain parties which we
19 feel should be primary parties to this inquiry.

20 Now, the question of counterfeit drug products
21 is a very interesting subject. This is something
22 this committee will be very interested in but in a
23 lot greater detail than it is dealt with in this
24 submission today.

25 I am interested in the statement and declara-
26 tion of the ethical objectives which are given on
27 your Page 1. We are also interested in whether or
28 not druggists are subjected to inducements by way
29 of special commissions to promote the sale of one
30 product as against another.



1 We are going to be very much interested in
2 the theory of pharmacists' prescription costs. There
3 are many aspects to that story. Can the drugs be
4 sold at a mark-up of a certain percentage and then
5 the pharmacists prescribing fee added? I do not know.
6 Those are all matters which are common knowledge,
7 surely, to those engaged in the trade itself.

8 Now, this committee is composed of eleven
9 men who have their own private interests, their
10 own personal commitments just the same as each one
11 of you and we are not advancing our time any by
12 obscuring or avoiding the issues which this committee
13 must deal with.

14 It is not my desire to be in the position
15 of delivering a lecture to anyone but simply to state
16 the position of the committee once and for all today.
17 Mr. Turnbull?

18 MR. TURNBULL: Mr. Chairman, on behalf of
19 my Ontario colleagues here this afternoon and those
20 who may read your words of this afternoon, I would
21 like to explain one thing. Drugs and drug prices
22 are of great concern not only to the National Organiza-
23 tion but to the Ontario Organization. When Mr.
24 Frost first announced the formation of the committee
25 we welcomed it. However, in reading the specific
26 terms of reference and referral therein to hospitals
27 and government institutional costs and prices it was
28 felt by my Ontario colleagues that they need not, if
29 I might use the term, stick their necks out and
30 devote a considerable amount of time to the preparation



1 of something that might not be of any interest or
2 value to the Committee.

3 However, on their behalf I think I can
4 readily assure the Committee through you, sir, that
5 we are prepared to co-operate and bring this Committee
6 any information it feels will be of value. After
7 listening to you I can see that the interests are
8 quite far reaching and I am sure that all the
9 associations involved in pharmacy work in Ontario and
10 at the national level, if they can be of assistance
11 they will be only too pleased to re-appear before
12 the Committee. Perhaps you could call a brief recess
13 during which time we could get the information.

14 We are not attempting, I assure you sir,
15 to hide anything but we are most anxious that the
16 Government and the government on behalf of the
17 people have an opportunity of gaining a proper
18 insight into pharmacy and drug distribution both in
19 Ontario and across Canada.

20 THE CHAIRMAN: Thank you, Mr. Turnbull. I
21 hope there is no doubt in your mind as of now about
22 the Committee's position.

23 MR. CROSSLEY: Mr. Chairman, I would like
24 to add to that the fact that the O.R.P.A. was given
25 slightly less than a week in which to prepare material
26 for this hearing. During that week we decided the
27 best thing would be to provide a very short and
28 generalized statement for the Committee. After
29 this statement was given if you decided to branch off
30 into specific areas we were quite prepared to follow



1 the facts and figures presented.

2 THE CHAIRMAN: Well now, this Committee was
3 appointed on April 6th last so I do not understand
4 in your reference to one week.

5 MR. CROSSLEY: Perhaps Mr. Smith could
6 clarify that.

7 MR. SMITH: Well, Mr. Chairman, I have to
8 rely on my memory. Mr. Gadsby phoned me a week ago
9 Friday to have this ready by the following Thursday.
10 I told him of an important meeting I had on Thursday
11 in London. Then he called me and I think he told
12 me I could have until Monday. I had appointments
13 out of town over the weekend.

14 Apart from that may I say with all humility
15 and reverence to your statements that I myself did
16 not in any way try to circumvent or anticipate circum-
17 venting any desires of your Committee. I looked at
18 the legislative record to see what the motion was
19 and I did not see anything in there relating to
20 retail pharmacy at all. I received no letter from
21 you outlining what I should do. I went to two sources:
22 I went to the dean of our faculty and he said anything
23 I could give you would be a repetition. I went
24 to Professor Fuller and he said he was appearing on
25 a certain day, Tuesday or Wednesday, and I said,
26 "Now, you have some good material and I can use it."
27 I am not a pharmaceutical economist, I do not have
28 these figures. He teaches this as a subject with
29 the faculty. He said, "If you use it it will be a
30 repetition." I quoted sections to him that I thought



1 would be valuable in the brief. He said, "Well, I
2 intend to read the whole thing on Tuesday."

3 I feel that while apologizing to you for
4 not measuring up to your wishes, I do not know what
5 else I could do.

6 THE CHAIRMAN: I think the position will
7 probably be clarified after today. Perhaps we
8 should just leave it at that, Mr. Smith, with
9 no reflection on anyone because none is intended.
10 Our objective is to simply move this committee along
11 and get it moving as quickly as we can and get at
12 the facts.

13 Now, coming back to the Dental Association;
14 does your organization have any statistical set-up
15 or do you take statistics, Mrs. Durham?

16 MRS. DURHAM: No, we do not.

17 THE CHAIRMAN: What is the prime purpose
18 of your association?

19 MRS. DURHAM: Dental health education. We
20 have a lot of material that we lend out to people
21 for dental health education. We look after the
22 profession to a point. We have a fee schedule, as
23 I am sure everyone knows and we have a convention
24 where we bring on the advancement of new types of
25 dentistry. We also have a monthly magazine.

26 THE CHAIRMAN: What subjects does it cover?

27 MRS. DURHAM: All subjects pertaining to
28 dentistry.

29 THE CHAIRMAN: Including the use of drugs?

30 MRS. DURHAM: No.



1 THE CHAIRMAN: Anything about anaesthesia?

2 MRS. DURHAM: Not very much. I do not
3 think I can remember them having an article on anaesthesia.

4 THE CHAIRMAN: Will you check that and let
5 us know?

6 MRS. DURHAM: I can check it and let you know,
7 yes.

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Page 444 follows.

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THE CHAIRMAN: Here is the situation.

I have expressed my views about it, and I hope that we don't have many other days like today. Have you any observations, gentlemen?

MR. BOYER: I think, Mr. Chairman, your remarks are very well taken. It is this Committee which will decide what information it wants and not others.

MR. TROTTER: Mr. Chairman, could I make a similar observation which you made the other day, that some of these organizations should receive questions from us, because there were two here the other day that were not sure what we wanted. It may be that the druggists were in the same situation, although I must admit it is quite surprising that the dentists did not even see fit to answer us.

I think if they were supplied with certain questions, we might get the answers that we want.

MR. WREN: The only observation that I have to make is that I think you have covered the situation rather fully. I know in my own case I travelled 1,000 miles to attend these Committee hearings. I have been on a good many of them during the years I have been in the Legislature, and it seems to me that some people seem to think that this inquiry is going to be a boy scout group. I don't intend to be treated like a boy scout, and I don't think any other member of the Committee does. Certainly, people like



1
2 the Dental Association have a firm obligation to be
3 prepared to come before this Committee and give infor-
4 mation. I agree whole-heartedly and I know by
5 colleagues do with the Chairman, that the Legislature
6 does not intend that this Committee will just be a
7 rather insignificant matter, because there is wide
8 public interest. I think every member of the
9 Legislature has very extensive files from people all
10 across the province who are deeply concerned about
11 drugs and the cost of them.

12 I would go along with your remarks, Mr.
13 Chairman, that people will take this seriously, which
14 would be of great assistance to us. I don't think we
15 want to bother anybody, or subpoena anybody, as the
16 Chairman says, but we do have these powers if people
17 don't pay heed to what are normal requests.

18 THE CHAIRMAN: There is one other item
19 that I would like to deal with, gentlemen. It is with
20 respect to the manufacturers and their position before
21 the Committee.

22 There is the Canadian Pharmaceutical
23 Manufacturers Association, but there are also other
24 companies who are not members of that association, and
25 frankly, Mr. Gilbert of the Gilbert Drug Manufacturing
26 Company would be one. Is Mr. Gilbert here today?

27 MR. GILBERT: Yes.

28 THE CHAIRMAN: Are there any other
29 manufacturers who are not members of the Canadian
30



1
2 Pharmaceutical Manufacturers Association?

3 MR. WILLIAM MILLER: Yes.

4 THE CHAIRMAN: Who do you represent?

5 MR. MILLER: The Maney Laboratories
6 (Canada) Limited.

7 THE CHAIRMAN: And what is your name?

8 MR. COOK: Mr. Cook, and I am also with
9 the Maney Laboratories.

10 THE CHAIRMAN: I am glad to see you here
11 today, because we will be looking to the non members
12 for information as well as from the Association. It
13 may well be that you would want to make a specific
14 submission to the Committee.

15 Mr. Gilbert, what is your position on this
16 at the moment?

17 MR. GILBERT: My position is that the cost
18 of drugs is high, and I would be happy to make a
19 statement, definitely.

20 THE CHAIRMAN: Is it your intention to
21 submit a brief to us?

22 MR. GILBERT: I would like to if I can have
23 sufficient time to do it.

24 THE CHAIRMAN: You were not here on
25 Friday. I would say this to you, gentlemen, that I
26 would not expect it - we will resume after this week
27 on October 19th, which is a Wednesday, and I would not
28 expect that it would be before October 24th. I am
29 not sure of the date even then, but would that be ample
30 time to draw your views?



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MR. GILBERT: It would be satisfactory.

THE CHAIRMAN: Mr. Miller, what would your position be with respect to this?

MR. MILLER: I am quite willing to draw up any information that the Committee would desire.

THE CHAIRMAN: The reason I am asking this is, I am trying to think ahead in terms of time and scheduling. Is it your desire to submit a brief to the Committee?

MR. MILLER: Frankly, I have no brief that I care to submit, because as far as I am concerned personally in the running of our own company, we do not have any particular problems.

THE CHAIRMAN: That is a happy position to be in. To Mr. Miller and to Mr. Gilbert, could I say this, are there any other non member manufacturers, who are non members of the Canadian Pharmaceutical Manufacturers Association that you know of who do business in Ontario?

MR. MILLER: Off hand, I could not be exact, but there are a number of smaller companies like ours that possibly are not members of the Canadian Pharmaceutical Manufacturers Association.

THE CHAIRMAN: It would be a real help to us, Mr. Miller and Mr. Gilbert, if you either would pass the word to those other non members that the Committee is sitting, and if they have any interest in making a submission, we would be glad to receive it.



1
2 On the other hand, you might feel you might
3 be able to help the Secretary by giving him a list of
4 companies that you know about who are not members of
5 the association. That would be helpful.

6 On Friday I mentioned that we are interested.
7 We would like to have a record of these companies,
8 telling us where the head office of the company is,
9 if it is a Canadian company, if it is Canadian owned,
10 if it has research facilities, and if so where they are
11 located, as well as some basic information that we
12 can collate.

13 Mr. Gilbert indicated that he was going to
14 make a submission, and I should also like to say this,
15 that as we get into the real meat of the work before
16 us, there will be an opportunity for cross-examination
17 of the witnesses. To date it might be said that the
18 evidence has been of a non controversial nature. I
19 would expect that in the days ahead, that the witnesses
20 would be subject to cross-examination by parties
21 having an adverse, or having any interest in this
22 hearing. I think we should keep that in mind.

23 Gentlemen, is there anything further?

24 MR. WREN: Mr. Chairman, regarding this
25 submission of the Ontario Retail Pharmacists' Association

26 ---

27 THE CHAIRMAN: Yes.

28 MR. WREN: The beginning of the last
29 paragraph, on page 3, mention is made of the counter-
30 feiting operations in Hoboken, New Jersey.



1
2 On page 4 it says:

3 "The names of several Canadian companies
4 were in the list."

5 I think it would be helpful to us when these gentlemen
6 appear again, if they would bring us a report of the
7 source of this report, so that we may identify those
8 Canadian companies that are mentioned here.

9 THE CHAIRMAN: Could that be done, Mr.
10 Smith?

11 MR. SMITH: I will do my best, sir, I am
12 not sure.

13 THE CHAIRMAN: you might follow that up,
14 Mr. Rice, as our solicitor.

15 Are there any other questions or comments
16 that the members have to make on this point?

17 MR. SUTTON: To return again to the
18 subject of the Ontario Dental Association, could it be
19 that the gentleman or the dentist with whom our
20 Secretary was in touch, in view of the fact that he
21 was President-Elect and not the immediate past
22 President, that he may not have been familiar with his
23 duties, and therefore the Secretary should be in touch
24 with the immediate past President of the Ontario Dental
25 Association.

26 THE CHAIRMAN: Could you give us a list
27 of the officers, Mrs. Durham?

28 MRS. DURHAM: Yes, I can.

29 THE CHAIRMAN: Have you got them with you?
30



1
2 MRS. DURHAM: No, but I can write them out
3 for you.

4 THE CHAIRMAN: That would be helpful. Will
5 you leave them with Mr. Gadsby?

6 MRS. DURHAM: Yes I will.

7 THE CHAIRMAN: There is nothing else for
8 us to consider today, and accordingly we will adjourn.
9 What is on the agenda tomorrow, Mr. Gadsby?

10 MR. GADSBY: At 10 o'clock in the morning,
11 Dr. White from the Ontario Dental Association. At
12 10.30, Professor Fuller will be here.

13 THE CHAIRMAN: And at 3.00 p.m., Dr. Ian
14 MacDonald, Director of Post Graduate Studies, University
15 of Toronto, will be available.

16 I would suggest, then, we meet tomorrow at
17 10.30, is that agreeable, Mr. White?

18 MR. WHITE: Yes.

19 MR. GADSBY: Dr. White asked if he could be
20 here at 10.00 o'clock. He has had to revise his
21 schedule once, and I said that I would bring it to the
22 attention of the Committee.

23 THE CHAIRMAN: We shall turn the other cheek
24 and meet at 10 o'clock. This is adjourned until
25 tomorrow morning at 10 o'clock.

26
27 --- Adjournment.
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Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO ONTARIO

VOLUME No.:

7

DATE:

OCT 4 1960

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1
2 SELECT COMMITTEE ON DRUGS

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4 Proceedings of hearings
5 held at Parliament Buildings,
6 Toronto, Ontario, on Tuesday,
7 the 4th of October, 1960,
8 at 10.00 a.m.
9

10 COMMITTEE:

11
12 MR. H. L. ROWNTREE, Q.C. Chairman
13
14 -----

15 MR. A. WREN

16 MR. J. A. FULLERTON

17 MR. J. TROTTER

18 MR. R. E. SUTTON

19 MR. R. J. BOYER

20 MR. N. WHITNEY

21 MR. H. J. PRICE

22 MR. K. BRYDEN

23 MR. J. WHITE

24 MR. G. F. LAVERGNE
25 -----

26
27 MR. S. J. GADSBY, F.C.I.S., Secretary
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1 THE CHAIRMAN: Gentlemen, we will resume
2 the inquiry. This morning I have received confirmation
3 from the Department of the Secretary of State indicating
4 that they propose to send the Commissioner of Patents
5 here before the Committee, to deal with technical
6 aspects of the Patent Act, and its operation, particu-
7 larly with reference to drugs.

8 Now, Mr. Rice was going to proceed. I see
9 Dr. White is here.

10 DR. E. A. WHITE: (Comes forward)

11 MR. RICE: The purpose of this inquiry is
12 to inquire and to study and review the cost of drugs
13 in Ontario. This, of course, is to include the
14 purchase and distribution of drugs and inventory of
15 drugs.

16 Now, we understand that dentists use drugs.
17 Is that correct?

18 DR. WHITE: Yes.

19 MR. RICE: And dentists do have a right to
20 prescribe, do they not?

21 DR. WHITE: Yes.

22 MR. RICE: They are one of the select few
23 who have the right to prescribe, along with medical
24 doctors?

25 DR. WHITE: Yes.

26 MR. RICE: And you are one of the three
27 classes of persons who have the right to prescribe?

28 DR. WHITE: Yes.

29 MR. RICE: Do I understand you are a member
30 of the Dental Association? Is there a Dental Association?



1 DR. WHITE: What do you mean?

2 MR. RICE: Is there an association of dentists?

3 DR. WHITE: There are three Associations
4 which the dentists in Ontario - at least in Toronto -
5 may belong to. We belong to the Canadian Dental
6 Association which embraces every dentist in Canada.
7 We belong to the Ontario Dental Association which
8 embraces dentists in Ontario. And there is the
9 Dental Academy.

10 By right or by our license we are members
11 of the Royal College of Dental Surgeons.

12 MR. RICE: Which is the licensing body?

13 DR. WHITE: Royal College of Dental Surgeons.

14 MR. RICE: Are you an officer of any one of
15 those Associations?

16 DR. WHITE: At present I am the president-
17 elect of the Ontario Dental Association, and chairman
18 of the executive committee.

19 MR. RICE: Can any one of those Associations
20 voice for the members of the Association - that is
21 for the dentists in Ontario?

22 DR. WHITE: In what way?

23 MR. RICE: In this question of drugs we
24 are concerned with here. Can they speak more or less
25 for the dentists of Ontario?

26 DR. WHITE: We have no statistics. The
27 Ontario Dental Association is not formed to gather
28 statistics on any phase of drug purchase, or anything
29 used in dentistry. The purpose of the Ontario Dental
30 Association is to inform or advise the dentists of the



1 latest procedures, dental procedures, so that they
2 can be of better service and render better service
3 to the public.

4 MR. RICE: Would that include advising them
5 on the use of new drugs?

6 DR. WHITE: No. The only time they would
7 be advised on that would be through our clinical
8 sessions which we run. We bring in men from all over
9 the country to describe the latest concepts or the
10 latest procedures and technique and development of
11 skillful procedures for a dentist to employ in making
12 a person's mouth better than it is at present.

13 MR. RICE: Now, the Committee here is
14 interested in the use of drugs by dentists, and they
15 are interested in the charge that dentists make for
16 drugs, and how they are included in their accounts
17 and the inventory which dentists keep; the extent
18 to which they extend this right to prescribe, and
19 any submissions or any recommendations which you
20 wish to make to the Committee with regard to the use
21 and costs of drugs.

22 Now, would you rather make some brief up
23 along those lines for the Committee and present it
24 at a later date, or would you rather speak off the
25 cuff this morning?

26 DR. WHITE: The question of having to speak
27 off the cuff, we have no record of what a dentist's
28 purchase of drugs would be. They are not very great.
29 There are in the whole of Canada roughly 4,500 dentists.
30 The drugs - I think there is a misconception of drugs



1 in your terminology and ours. Our terminology of
2 drugs and those drugs which we have the impression
3 this Committee is investigating is the cost of drugs
4 which would be prescribed by us to a patient.

5 Now, dentists as a whole do not prescribe
6 very many drugs for their patients. I think you are
7 primarily interested in the antibiotics, and we
8 feel that if an infection is bad enough for a patient
9 to be in receipt of penicillin or its derivatives
10 that should be prescribed by the family physician,
11 because we do not know and we have no way of knowing
12 what allergy that patient may have to the drug, or
13 what side effect that drug may have on the patient,
14 so we prefer, and we think it is good dental practice
15 to do so, to refer that patient to their family
16 physician for that treatment. If we think it is
17 necessary we so advise the patient to go and see
18 the physician.

19 The drugs which we use in the office are
20 quite a few in number. We use phenol, silver nitrate, zinc,
21 oxide, eucalyptus, iodine, oil of cloves and alcohol.

22 Now, as far as the amount we use, we might
23 use one or two ounces a year. We use them in very
24 small quantities, with the exception of alcohol. As
25 far as alcohol is concerned we use that for sterilization,
26 and we use pure grain alcohol. We have no control
27 over the cost of that. We think it is exorbitant,
28 I know that. We think the dentist should be allowed
29 possibly the same freedom in buying alcohol for office
30 use as the hospitals when they receive it without



1
2 surcharge, government tax, and we pay the full cost.
3 We buy at the liquor vendors. We have a licence to
4 get it. We have a special licence to purchase it
5 which runs the cost of that drug up.

6 Now, those drugs are used in the office, and
7 they are part of our -

8 THE CHAIRMAN: The tax you are referring
9 to would be what, sales tax or excise tax?

10 DR. WHITE: Excise tax for alcohol. The
11 others are so small that we do not consider them an
12 expense actually. It is part of our daily work.

13 I understand, too, that you classify local
14 anaesthetics as a drug. Well, it is a drug, but we
15 use it in the same manner as we would use an x-ray
16 or a mouth mirror. It is part of our service and
17 good dentistry to a patient. Some dentists use
18 more than others, and it varies.

19 We buy that from our supply house. We do
20 not buy that at a drug store. We buy it direct from
21 our dental supply.

22 THE CHAIRMAN: What would the names of the
23 anaesthetics be that are used?

24 DR. WHITE: There are different names.
25 There are an awful lot of names. Novocain, zylcaine,
26 cobefrin. You can buy it in ampule form. Some
27 institutions especially when they have large dental
28 clinics in hospitals, the anaesthetic was purchased
29 in ampule form and a solution made up every morning
30



1
2 so there would be a fresh solution every morning, and
3 in that way, we were using such large quantities we
4 could have a fresh solution in the morning to use.

5 As I say, we figure that just the same as
6 using any hand instruments or anything else in the
7 office. It is part of our good dental procedure to
8 a patient to use it. Does that cover what you wanted?

9 MR. RICE: Can you tell us how much of
10 these drugs, or what size of inventory a dentists
11 usually carries in his office?

12 DR. WHITE: Well, the drugs I enumerated ,
13 we possibly carry, one, two or three ounces in our
14 stock. Alcohol, we would carry - when I buy alcohol
15 I get a little annoyed at it, so I get two quarts a
16 year. I don't drink it. The local anaesthetic, it
17 varies in price from \$13.00 a thousand roughly for
18 2 c.c.'s. Most of them use it in ampule form for we
19 know there is no contamination in getting at it and
20 it is enough for use of - some men use more than
21 others. It is just the technique they use and the
22 skill in which they use it.

23 MR. RICE: Could you give us some estimate
24 as to the value of the inventory a doctor would have?

25 DR. WHITE: I do not think the drugs that
26 we use in our office - a rough estimate - would be
27 more than \$5.00 a year. That is, the drugs I have
28 named. Other people may have a special preference
29 for some drugs which they use in their office. I
30



1
2 wouldn't know.

3 MR. WREN: What would the cost be of a
4 normal anaesthetic when you are performing an
5 extraction, say?

6 DR. WHITE: As I say, some of us give it
7 with one c.c. of anaesthetic which would roughly cost
8 15 cents, or 10 cents. I mean I am just trying to
9 break it down. There are three types of ampules you
10 can buy. One is one c.c., two c.c., and two and three-
11 quarters c.c. Some people prefer to use two and three-
12 quarters. I myself do not keep it in the office for
13 I do not have any use for it. I can get as good an
14 anaesthetic with 2 c.c.'s in solution as the other chap
15 can get with 2-3/4. It has no bearing on the actual
16 cost of drugs. We never think of it as a drug.

17 MR. RICE: Are all these obtained from
18 your dental supply house?

19 DR. WHITE: Some are and some are not.
20 You can obtain from the local drug store. They can get
21 them for you, or you buy them from your local dental
22 supply office.

23 MR. RICE: And what price would the dentist
24 pay for them, wholesale price?

25 DR. WHITE: No, retail price always.
26 I do not believe any dentist should encourage wholesale
27 buying. I mean, after all, other people have got to
28 live and we expect to live. Therefore, we should pay
29 what the price of the drug is at the retail price.
30



1
2 MR. RICE: Is there any special way in
3 which you bill to include this?

4 DR. WHITE: The drugs are never, to my
5 knowledge that we use in dental offices, billed
6 separately to a patient. It is all a part of our
7 procedure, of our service.

8 MR. RICE: I take it from what you said
9 before that the drug cost would be a very small
10 proportion of the bill in any event?

11 DR. WHITE: Correct, yes. That would
12 not include anaesthetics. It is a different
13 proposition. That would not include that cost. It
14 would raise it higher.

15 MR. RICE: Including local anaesthetic
16 that you use in your practice, what proportion of the
17 account of the patient would that be?

18 DR. WHITE: There would be no difference.
19 It does not have any effect on our service to our
20 patients.

21 MR. RICE: The dentists take the amount
22 they are going to pay for drugs into consideration
23 when they are setting charges to the patients?

24 DR. WHITE: The only way the dentist
25 arrives at the service to the patient, naturally there
26 is the cost of their office which is included along
27 with the cost of rent, the assistant's salary, or the
28 technician's costs - that is all lumped in together
29 and the cost of drugs has a part, surely, but it is not
30 specifically a part. It is not taken out and



1
2 considered as costing so much, and therefore, the fees
3 will be increased by so much. That does not have any
4 bearing on it.

5 MR. RICE: Is there a tariff for dentists?

6 DR. WHITE: Pardon?

7 MR. RICE: Is there a tariff for dentists?

8 DR. WHITE: Do you mean a tariff similar
9 to possibly the one the legal profession has?

10 MR. RICE: Or the medical profession.

11 DR. WHITE: There is no definite tariff
12 as far as dentists are concerned. We have what we
13 call a suggested or guide fee schedule which is purely
14 for the guidance of the dentist and varies in different
15 localities. The cost of services in the big city
16 naturally is more than in the small community. The
17 salaries paid to assistants in the dentist's office
18 varies across the country. There is no hard and fast
19 rule.

20 We cannot say, "If you are buying a vacuum
21 cleaner it is worth \$24.00 here, and it is worth \$24.00
22 in British Columbia." You could not say there is a
23 cost for one dental operation. It is not set down
24 as an item. It varies with the service given and the
25 difficulties encountered in performing that service.

26 MR. RICE: Who makes up this suggested
27 tariff?

28 DR. WHITE: It is made up by our Association.
29 There is also a tariff made up by the Workmen's
30



1
2 Compensation Act in which they will reimburse us for
3 dental services to their patients. There is also a
4 tariff made up by the Department of Welfare of the
5 Province of Ontario which is a fee that they will pay
6 to dentists for their services.

7 MR. RICE: Which one of these associations
8 is it that makes up the Association tariff, the Ontario
9 Association?

10 DR. WHITE: The Ontario Dental Association
11 makes up a suggested fee schedule. It is not a
12 tariff. It is a suggestion, a guide, mainly brought
13 out as a guide to the graduating students going out
14 into practice who have no idea of how to base their
15 fees or how to arrive at them. It is purely a guide
16 to help them carry out a fair practice to the public.

17 MR. RICE: Is the cost of the drugs that
18 the dentist uses taken into consideration when the
19 tariff is made up?

20 DR. WHITE: No.

21 MR. RICE: When a dentist uses the
22 tariff, does he make any allowance from the tariff by
23 reason of the drugs he is going to use?

24 DR. WHITE: Not to my knowledge, he would
25 not, no.

26 MR. RICE: I understand you said the
27 Workmen's Compensation made a tariff. Does their
28 tariff include drugs?

29 DR. WHITE: No, it does not.
30



1
2 MR. RICE: When you send a bill to the
3 Workmen's Compensation Board, do you have to set aside
4 drugs separate from other fees?

5 DR. WHITE: No, there is no provision
6 made to my knowledge for any charge for drugs as such
7 in any of these fee schedules.

8 MR. RICE: Mr. Chairman, would the
9 Committee like to request copies of these tariffs to
10 be filed? Could we have them?

11 DR. WHITE: As far as the Ontario Dental
12 Association's tariff is concerned, the fee schedule,
13 at least, - as far as the Ontario Dental Association
14 is concerned, it is given only to graduates of the
15 College.

16 MR. RICE: Could not copies be made
17 available to the Committee?

18 DR. WHITE: It has not been the practice
19 of the Association to give those fee schedules to
20 anybody unless they are a practising dentist.

21 MR. BOYER: I think, Mr. Chairman, in some
22 dental offices this schedule is displayed on the wall
23 of the office, and I think we should have the right to
24 have it if we want it.

25 MR. SUTTON: I would not think that would
26 be important to this Committee at all. He has told
27 us the account is made up of so much for a piece of
28 bridge work, so much for an inlay, so much for a filling
29 and there is no mention of drugs, the witness says,
30



1
2 and it does not apply to us at all.

3 DR. WHITE: Furthermore, the fee schedule,
4 to be interpreted, would have to be studied by a
5 dentist. It would not mean a thing to a person who is
6 not familiar with our terminology.

7 As far as the fee schedule being displayed
8 in the offices of dentists' waiting rooms, we regret
9 very much that it is there. It has caused some
10 dentists embarrassment by being displayed to patients
11 because they think that is the fee, and you don't go
12 beyond it or you don't go below it, which is not fair.

13 The fee as suggested, in some cases can be
14 reduced and in some cases increased due to the
15 difficulty encountered in working on that patient.

16 MR. WREN: It has to be interpreted.

17 DR. WHITE: It has to be interpreted and
18 I am not saying anything against the members of this
19 Committee, but unless they are acquainted with dental
20 terminology, they would have difficulty in interpreting
21 it.

22 THE CHAIRMAN: Dr. White, in your expenses
23 for a year, what would the item total for drugs. I am
24 not including supplies of swabs or things of that
25 sort.

26 DR. WHITE: That would be a very difficult
27 item to arrive at because we receive our amounts from
28 the supply houses which includes an item for dental
29 supplies. Drugs we buy at the drug store and generally
30



1
2 we pay cash and as such they are not kept account of.

3 THE CHAIRMAN: In your profit and loss
4 statement which is required for your tax returns,
5 don't you have that?

6 DR. WHITE: Most dentists do not make a
7 profit and loss return.

8 THE CHAIRMAN: They would have a statement
9 showing their receipts less their expenses.

10 DR. WHITE: That is right, but we do not
11 list them. The only way you can make a profit and
12 loss statement would be to estimate your services for
13 the year, take away your receipts, and take away your
14 amount uncollected, and that would be your loss. Most
15 people do not do that.

16 MR. WREN: I should say not.

17 THE CHAIRMAN: Let us confine ourselves
18 then to a statement. I am trying to get on some
19 common ground with you. Let us confine ourselves
20 to a statement of your profit on your operations for
21 the year. The one figure, I believe, would be gross
22 revenue.

23 DR. WHITE: The gross revenue. Next
24 would be your net costs, and the next would be your
25 income.

26 THE CHAIRMAN: That is right, and in the list
27 of costs there would be telephone, and there would be
28 rent?

29 DR. WHITE: But drugs are not a separate item.
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THE CHAIRMAN: You do not separate them?

DR. WHITE: No.

THE CHAIRMAN: Would you care to give an estimate? Is it \$50.00 a year or \$500.00 a year?

DR. WHITE: For which?

THE CHAIRMAN: For the drugs that you purchased in a year, twelve months span?

DR. WHITE: It would be awfully hard to do that, because as I say some people might use - well, as drugs as we call them, I would not say they would go over \$50.00, according to our terminology of drugs.

THE CHAIRMAN: What about the item of anaesthetics?

DR. WHITE: Anaesthetics would vary greatly. Some people will use 2,000 ampules a year and others would use only 500. It all depends.

THE CHAIRMAN: How much did you say ampules are worth?

DR. WHITE: They are worth roughly \$15.00 a hundred. No, that is wrong. Yes, \$15.00 a hundred. It would be \$150.00 a thousand.

THE CHAIRMAN: Do you think that the range would be from \$200.00 to \$500.00?

DR. WHITE: It could be.

THE CHAIRMAN: So the item, if we said 300, would be \$45.00?

DR. WHITE: Yes.

THE CHAIRMAN: Did you say \$200.00 to \$500.00 or \$500.00 to \$2,000.00?



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2 DR. WHITE: \$500.00 to \$2,000.00, it could
3 be.

4 THE CHAIRMAN: If we took \$1,000.00 then,
5 ---

6 DR. WHITE: Yes.

7 THE CHAIRMAN: They would run you about
8 \$150.00?

9 DR. WHITE: Yes.

10 THE CHAIRMAN: And another \$50.00 for the
11 items that you regard as drugs?

12 DR. WHITE: At the most. That would be a
13 very high estimate, unless you had a sloppy assistant
14 who spilled them all the time.

15 THE CHAIRMAN: How many practising dentists
16 are there in Ontario?

17 DR. WHITE: 2,430.

18 THE CHAIRMAN: If you take 200 times 2,430,
19 you will have \$486,000. That is half a million
20 dollars.

21 DR. WHITE: It is just a rough estimate on
22 my part. I have no figures to substantiate that
23 as a definite figure, but from my own experience and
24 from what other men use in their offices, I would say
25 roughly that is what these dentists might use.

26 THE CHAIRMAN: Has any analysis ever been
27 made? Professor Fuller is going to present his
28 analysis of the retail drug stores and their financial
29 position and their operation. Has any study ever
30 been made of the costs of operation of a dental office?



1 DR. WHITE: None whatever. We have never
2 had an inquiry or a survey of any plan or any
3 complaint made to us officially of the high cost of
4 any of these items and as I say, local anaesthetics
5 go arm in arm in many cases.
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1 MR. RICE: Of these 2,430 practising dentists,
2 how many of those would be members of your Association?

3 DR. WHITE: They are all members of our
4 Association.

5 MR. RICE: How do those members or dentists
6 keep up, or keep abreast of the times, on new drugs
7 particularly?

8 DR. WHITE: Actually, as I said before, most
9 of them who think that a patient is in need of drugs
10 which have an effect on the whole body, they refer them
11 to the medical profession for that service.

12 We don't study drugs in the same manner as
13 medicine does because we are not treating the whole body.
14 Our main source, or our main site of operation is the
15 mouth.

16 MR. RICE: How do they keep abreast of the
17 drugs that are used in industry? In local anaesthetic?

18 DR. WHITE: The drugs we have -- in local
19 anaesthetic?

20 MR. RICE: Yes.

21 DR. WHITE: We have those -- we keep
22 abreast of that type of drug, local anaesthetic, at
23 our conventions, at our meetings of the Society in which we
24 have commissions come to us and if they have found a
25 better way, if it is a better anaesthetic, we are told
26 about it but we are not told about it until they have
27 thoroughly tested it.

28 MR. RICE: Are there any publications to
29 dentists in which information with regard to new drugs
30



1 applicable to dentistry ---

2 DR. WHITE: None to my knowledge.

3 MR. RICE: Do detail men of manufacturers
4 visit dentists to acquaint them with new drugs?

5 DR. WHITE: At times the detail men will come
6 to the office and tell you the drugs that are available,
7 if you wish to use them. They describe them to you and
8 tell you what they will do and what they won't do.

9 MR. RICE: Do the dentists receive samples
10 from manufacturers of new drugs?

11 DR. WHITE: No. The only samples we receive
12 in our office are namely, aspirin, sedatives which
13 contain an eighth of a grain of codeine which a
14 patient can buy without prescription at a drug store.

15 MR. SUTTON: Malted milk, toothpaste. You
16 are deluged with them. My Dad was a dentist. We used
17 to get all these samples.

18 DR. WHITE: Yes, at one time our detail men
19 used to ---

20 MR. SUTTON: Get them every week.

21 DR. WHITE: They found out it was a pretty
22 costly business and they are cutting it down. I rarely
23 get samples in my office of toothpaste. It is very
24 rare now. One time I would agree that you had so much
25 you didn't know what to do with it. Now you don't get it.

26 MR. SUTTON: Toothbrushes and toothpaste.

27 DR. WHITE: You get toothbrushes, but that is
28 not a drug.

29 MR. RICE: Does your Association have any
30



1 control of its members; have any Discipline Committee
2 or anything like that?

3 DR. WHITE: The Ontario Dental Association
4 is a voluntary body, primarily, as I said for the
5 giving of knowledge of the latest methods. The only
6 person who has control on us for discipline is the
7 Royal College of Dental Surgeons.

8 They have a Discipline Committee and they
9 can discipline us.

10 MR. WREN: Do Ontario dentists admit patients
11 to public hospitals?

12 DR. WHITE: At present, no. We are trying
13 to. We have had communications with the Ontario
14 Hospital Board. At the present time, until the
15 Act, I believe, has been amended dentists as such
16 cannot admit a patient to the hospital.

17 I could when I was on the hospital staff
18 admit my own patients but I had to be a member of the
19 hospital staff to do so. The procedure would be to
20 admit a patient through their physician, and then you
21 take over for dental services in the hospital.

22 MR. RICE: Is there a common type of book
23 that dentists keep, that is for bookkeeping purposes?
24 Is there a common way they set their books up?

25 DR. WHITE: Well it varies. Some dentists
26 keep a very complicated set of books. Others mainly
27 keep a day book in which they record the fees of the
28 patient by day, total into a monthly summary, and then
29 into a yearly summary.
30



1 MR. RICE: I was thinking particularly in
2 the purchases of drugs. Is there any way that is
3 common to dentists that he has to keep their drug
4 purchases separate from other purchases, and keep track
5 of the drugs they purchase?

6 DR. WHITE: No, there is no requirement for
7 us to do so, and as I say, when you buy it from the
8 supply houses it goes in as a dental supply and is
9 just bulked as dental supplies.

10 MR. RICE: And the ordinary practising
11 dentists would reflect on his books anywhere just
12 what his inventory of drugs would be at any particular
13 time?

14 DR. WHITE: I don't think so. I don't see --
15 some men possibly are more meticulous than others,
16 who want to know exactly what they spend, but they
17 are few and far between.

18 MR. RICE: Is there much wastage in the
19 drugs that are used by dentists?

20 DR. WHITE: Not in the drugs we use, no.
21 There might be a wastage among anaesthetic, but not,
22 in our terminology of drugs.

23 MR. WREN: This schedule of fees, this
24 suggested schedule of fees is a patient entitled to
25 see that at any time?

26 DR. WHITE: No. It is for our own infor-
27 mation. For our own interpretation.

28 MR. WREN: How does it compare with say
29 the Workmen's Compensation Board fees? Is it higher
30



1 or lower?

2 DR. WHITE: In some instances it is lower.
3 In others, it is equal to. Not higher.

4 THE CHAIRMAN: What are the names of the
5 dental supply houses, Dr. White?

6 DR. WHITE: The National Refining, Dominion
7 Dental, Dental Company of Canada, Ash Temple.

8 MR. SUTTON: Is S.S. White still in business?

9 DR. WHITE: S.S. White is still in business,
10 but their distributors are the Dominion Dental Company.
11 There are others across Canada, but those are the
12 main ones in Toronto.

13 MR. RICE: Do you find that there is much
14 variance in the price of drugs when you buy them when
15 you buy them from the different supply houses?

16 DR. WHITE: No, I never actually checked that
17 because that is such a small item, don't bother with
18 it.

19 MR. RICE: Can you give the Committee any
20 statement as to how widely this right to prescribe
21 is exercised by dentists? I believe you said it was
22 quite small. Can you elaborate on that at all?
23 They have a right to prescribe?

24 DR. WHITE: Well I don't think it is
25 widely exercised. I have no way of knowing.
26 Some men -- myself, I purchase codeine, and acetylsali-
27 cylic acid in quarter and half, and if a patient --
28 if I think they need it, I will give them a couple
29 or two or three tablets and no charge for it.
30



1 It is part of my service, and I don't think -- I think
2 it is very wrong to write out a prescription for a
3 dozen tablets in which they will only use two or three,
4 and the possibility that a child at home might get a
5 hold of those, might have a very bad effect on them.
6 I think it is safety precautions, as far as I am
7 concerned. I don't know whether it is general
8 practice or not. Every man handles his practice
9 separately.

10
11 MR. RICE: Are there any recommendations
12 that you would like to make either personally, or on
13 behalf of the Association to the members of the
14 Committee with regard to handling the purchasing,
15 dispensing of drugs?

16 DR. WHITE: I don't think there is. If in
17 medicine, where you prescribe drugs, I would say yes,
18 there should be recommendations. As far as a dentist
19 is concerned, I think it is quite satisfactory just
20 the way it is being done now.

21 MR. RICE: Do you subscribe to this dentist's
22 right to prescribe should be continued and they should
23 have this wide right to prescribe any drug at all?

24 DR. WHITE: As far as sedatives are con-
25 cerned, I think the practice for the dentists --
26 They should have the same right as a medical man so
27 that he can do two things: so that he can purchase
28 the drugs himself for his use; have it available to
29 his patients, or in cases of some instances where he
30 might wish to prescribe a drug for a patient who was



1 going away, and was not available, to get the supply
2 from him.

3 MR. RICE: The position is today a dentist
4 can prescribe any drug at all to any person; is that
5 correct?

6 DR. WHITE: No, that is not correct. For
7 instance, I could not prescribe a cough medicine, say,
8 for my child which contains a narcotic.

9 MR. RICE: Well apart from your child.

10 DR. WHITE: I can prescribe it for a patient,
11 but I would be very foolish because it doesn't enter
12 into the practice of dentistry.

13 MR. RICE: I fully appreciate that, Dr.
14 White. I just wanted to bring out the fact that a
15 dentist has a wide right to prescribe.

16 DR. WHITE: As far as it pertains to the
17 practice of dentistry, yes.

18 MR. WREN: Is that an ethical requirement or
19 statutory requirement?

20 DR. WHITE: Which one?

21 MR. WREN: Your right to prescribe, is that
22 set out by statute?

23 DR. WHITE: That is set out by Federal
24 Statute.

25 MR. SUTTON: Dr. White, dentists that are
26 specializing in the extraction of teeth, if you have
27 ever had a wisdom tooth out, some of these men charge
28 \$30 for the operation, and they send you away with a
29 supply of yellow pills if you have any pain in your
30



1 mouth, or a supply of white pills if you can't get to
2 sleep that night. Don't you suppose they keep a very
3 large supply of drugs on hand? They just give them to
4 you in an envelope out of their own supply.

5 DR. WHITE: I wouldn't think so. I would
6 think they would buy in a 100 bottle lot.

7 MR. SUTTON: Would you think their drug
8 bill would be under \$500 in a year?

9 DR. WHITE: I wouldn't think it would be
10 any more.

11 MR. SUTTON: My guess it would be \$5,000.

12 DR. WHITE: I wouldn't know. I wouldn't know,
13 but from my own experience ---

14 MR. SUTTON: A man like Dr. Morgan, for instance.

15 DR. WHITE: I doubt it. Could be, but I
16 would have no way of knowing. You see, there are only
17 across Canada 40 men who have their specialization in
18 oral surgery. There are about 50 in Ontario and that
19 is a specialty field, although when I was in hospital
20 services why I used drugs -- the drugs usually were
21 prescribed by the intern and I believe we did the same
22 operation as they did in the specialty field but I
23 wouldn't think the drug bill in any dental office
24 would be over \$500 a year, at the most. I could be
25 wrong. I have no statistics.

26 MR. BOYER: Would more drugs be used in the
27 special field of which you spoke than in ordinary
28 practice?

29 DR. WHITE: There could be used -- but normally
30



1 an extraction is not confined to an oral surgeon.
2 It is done by every practising dentist.

3 MR. RICE: Mr. Chairman, do you want to make
4 a ruling on this tariff?

5 THE CHAIRMAN: I would be bound by what
6 the Committee desires. I am wondering if that point
7 might not be just set aside for the moment and we
8 will see, when we review the evidence we will see if
9 it is going to give any assistance to us.

10 DR. WHITE: May I speak to that? I really
11 don't think it would be of any assistance to you,
12 because drugs are not specifically mentioned in any
13 way, shape, or form.

14 MR. WREN: The point arises, Doctor, that
15 sometimes some dentists charge an extraordinary
16 fee, shall we say, and they base their reason on the
17 fact that the cost of drugs has increased considerably
18 over the past ten years so it may be that your
19 tariff fees would be interesting to the Committee later
20 on after we see the other evidence.

21 DR. WHITE: I don't think so. I have been
22 around this Province from one end of it to the other
23 in different capacities as far as the dental fields
24 are concerned.

25 MR. WREN: Would you say that in an uncompl-
26 cated extraction that a \$15 fee was high or low?

27 DR. WHITE: I couldn't tell you. I couldn't
28 tell you. You must remember that the difficulty --
29
30



1 the co-operation of patients has a lot of bearing;
2 time element has a lot of bearing and the after
3 treatment has a lot of bearing.
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16 ---Page 483 follows.
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1 MR. RICE: Has the tariff changed in the
2 last five years?

3 DR. WHITE: It is under revision at the
4 present moment.

5 MR. RICE: Has the one that is under revision
6 been revised previously?

7 DR. WHITE: No, we never had one until it was
8 brought up. We never had a suggested fee schedule
9 until one was brought out in 1958 and that is under
10 revision now.

11 MR. RICE: And that is under revision by
12 your association, is it?

13 DR. WHITE: That is right.

14 MR. RICE: And is the cost of drugs going
15 to be a factor in revising the schedule?

16 DR. WHITE: No, the cost of drugs is not
17 even considered.

18 MR. RICE: Those are all the questions I
19 have.

20 MR. WHITE: If you order a variety of
21 supplies from a supply house, supply of aspirin and
22 spatulas and ampules of anaesthetic and perhaps one
23 or two drugs, do you mean to say the quantities
24 will not be totalled on the invoice?

25 DR. WHITE: No, they are totalled on the
26 invoices but as far as we are concerned in our account-
27 ing it would just be "dental supplies - so much".

28 MR. WHITE: Mr. Chairman, the estimates that
29 we have arrived at here vary so greatly between a
30 few hundred dollars and now \$1 $\frac{1}{4}$ million. A moment ago



1 someone said \$5,000 per dentist --

2 MR. SUTTON: Not per dentist, for a special-
3 ist.

4 MR. WHITE: There is a very wide variation.
5 I am wondering if the Dental Association would not find
6 it helpful in their own interests to determine the
7 drug costs in the province. When they are reviewing
8 their own tariffs a small questionnaire could be
9 prepared by the secretary of our Committee working
10 in co-operation with one of the executives of this
11 Association to find out more specifically what drugs
12 are costing the dentists of the province. That is
13 something I would like to see done in the absence of
14 that information.

15 DR. WHITE: We cannot be definite. I am
16 here giving estimates from my own experience.

17 MR. WHITE: That is what I say, we should
18 be more specific. To do this I think we should send
19 a questionnaire with the co-operation of the dentists
20 to see how much drugs are costing.

21 DR. WHITE: We would be willing to co-operate
22 in any way we can to help this Committee to arrive
23 at their conclusions.

24 MR. WREN: Dr. White, you say you just take
25 the total of the invoices and enter it in your books
26 as a cost. Do not the Federal authorities make you
27 keep track of the drugs, the habit forming drugs?

28 DR. WHITE: We are controlled on our habit
29 forming drugs in this way: if a dental practitioner
30 is prescribing an abnormal amount of narcotics he is



1 contacted by the R.C.M.P. and asked about it. We are
2 controlled through that procedure.

3 MR. WREN: If a R.C.M.P. man visits you
4 and you just have a sum total -- ?

5 DR. WHITE: When the R.C.M.P. visits you
6 they have a record of the drugs you have bought from
7 the drug store and they come up and ask you why and
8 you have to explain it.

9 MR. WREN: But would you explain it?
10 You have no records to show whether you did or did
11 not?

12 DR. WHITE: If you buy an abnormal amount
13 of narcotic drugs that the rest of the dentists in
14 Ontario and Canada do not buy then "What are you doing
15 with it?" That is their question.

16 MR. PRICE: Mr. Chairman, I think a lot of
17 that information could probably be supplied by the
18 dental supply houses. That is a field we have not
19 gotten into at this point but obviously they can
20 give us a lot of information that we may have difficulty
21 getting elsewhere.

22 DR. WHITE: They can give you exact figures,
23 they know the amount of drugs sold. As I say, \$4,000,
24 that is what they figure the drug costs in 1959 were
25 for the drugs I mentioned. That does not include
26 local anaesthetic because they do not consider that a
27 drug.

28 THE CHAIRMAN: \$4,000?

29 DR. WHITE: For the whole of Canada but that
30 does not cover them all. If I want two or three ounces



1 of iodine I go to the drug store to get it because
2 the cost is so little.

3 THE CHAIRMAN: Are there any other questions,
4 gentlemen? Dr. White, your remarks have been very
5 helpful to the Committee in dealing with this subject
6 from your point of view and we thank you for coming.

7
8 PROFESSOR HORACE J. FULLER (called)

9 MR. RICE: Professor Fuller, what is your
10 occupation?

11 PROF. FULLER: Professor of Pharmacy Admin-
12 istration, Faculty of Pharmacy at the University of
13 Toronto.

14 MR. RICE: And how long have you been in
15 that position?

16 PROF. FULLER: At the University of Toronto
17 for nine years. As far as teaching experience is
18 concerned I am not beginning my 34th year.

19 MR. RICE: What subjects do you specialize
20 in?

21 PROF. FULLER: I am a registered pharmacist
22 in the Province of Ontario and in the State of
23 Connecticut in the United States. My graduate work
24 was in the Department of Economics at Yale University.

25 MR. RICE: And is that what you teach?

26 PROF. FULLER: I teach basic economics,
27 accounting, drug marketing and pharmacy management.

28 MR. RICE: And are you connected with any
29 pharmaceutical association?

30 PROF. FULLER: The only way I am connected



1 with any pharmaceutical association is that I write
2 a monthly article for the Canadian Pharmaceutical
3 Magazine which is owned and operated by the Canadian
4 Pharmaceutical Association. For the last nine years
5 I have made a survey on pharmacy operations in
6 Canada for the Canadian Pharmaceutical Association.

7 MR. RICE: Are you a member of that Associa-
8 tion?

9 PROF. FULLER: My understanding is that
10 all pharmacists in Canada are automatically members
11 of the Association by virtue of the fact that they
12 pay their fees to the College of Pharmacy.

13 MR. RICE: I understand that you have a
14 paper which you would like to submit to the Committee?

15 PROF. FULLER: That is right, sir.

16 MR. RICE: Then, if you will proceed.

17 PROF. FULLER: Mr. Chairman, ladies and
18 gentlemen. In the first submission to this Committee,
19 Dean F. Norman Hughes of the Faculty of Pharmacy,
20 the University of Toronto, said, "It would
21 seem desirable that you should have more detailed
22 expert testimony concerning several aspects in particular.
23 I would suggest, therefore, that you will wish to invite
24 expert witnesses for information on such topics as:
25 Hospital Pharmacy; the Canadian pharmaceutical industry;
26 Retail pharmacy and pharmaceutical economics."

27 I must leave it to you gentlemen the degree
28 of expertness that I hold but as I explained a few
29 minutes ago I am a pharmacist and I am a practising
30 economist.



1 I appear before you at the request of the Min-
2 ister for the purpose of providing factual information
3 concerning "Retail pharmacy and pharmaceutical economics."

4 There are 8,000 pharmacists, employed or
5 self-employed, in 4,883 pharmacies in Canada, 3,300
6 of whom are employed or self-employed in 1,954 pharmacies
7 in Ontario.

8 First, I think it wise to place the activities
9 of these 8,000 pharmacists in proper relationship to
10 our economy as a whole. From the financial viewpoint,
11 just how important are the economic activities of
12 pharmacists?

13 To an individual, income is either the money
14 or the goods which he receives in a given period,
15 such as a year. National Income, like individual income
16 may be thought of as either money or goods. It is
17 the annual money income of the nation as a whole, or
18 its annual real income as represented by the national
19 output of goods and services. However, as in the case
20 of individual income, National Income is usually
21 expressed in terms of money since there is no convenient
22 way of measuring a great variety of goods and services
23 except by estimating their total money value.

24 Undoubtedly the most useful economic statistics
25 are those that describe production and income from
26 a national standpoint. The Dominion Bureau of Statistics
27 (DBS) periodically issues a publication entitled,
28 National Accounts - Income and Expenditure, which
29 represents many data pertaining to the National Income
30 of Canada.



The flow of money to people involved in the process of production is the National Income. It is the total of money receipts to the nation as a whole in payment for the services of productive factors in a given period. It may be gross or net. The sum total of final goods and services accruing to society is the gross real national income - usually referred to as Gross National Product (GNP). No allowance is made for wear and tear of capital equipment hence if we subtract depreciation we get Net National Income (NNP).

If we subtract further indirect taxes such as gasoline and sales taxes (\$4,410,000,000 in Canada in 1959 - \$252 per person) but add transfer payments and subsidies such as family allowances, old age security fund payments, workmen's compensation benefits, interest on the public debt, payments to western grain producers (\$3,722,000,000 in Canada in 1959 - \$213 per person) we get Personal Income. We can go one step further and subtract what we pay as personal income tax. What is then left is Personal Disposable Income and we can spend it on Consumption or we can Save it as our hearts so desire.

The Gross National Product of Canada in 1959 was

\$35,593,000,000

Personal Income was 25,940,000,000

Personal Disposable Income was 23,852,000,000

of which we spent on CONSUMER G

GOODS AND SERVICES 22,261,000,000

and saved 1,591,000,000

(Population in Canada in 1959 - 17,442,000)



1 Of this \$22,261,000,000 Personal Expenditure
2 on Consumer Goods and Services, we spent \$16,148,965,000
3 in Retail Stores (Bulletin of Retail Trade, December
4 1959 (DBS))

5 Of this \$16,148,965,000 spent in Retail
6 Stores, \$503,351,861 (18th Annual Survey of the Canadian
7 Pharmaceutical Association) or 3.1% was spent in
8 Retail Pharmacies. Put in different fashion → 1.45%
9 of our Gross National Product flowed through Canadian
10 pharmacies.

11 Of this \$503,351,861 spent in Retail Pharmacies
12 \$130,871,483 was spent on Prescribed Medicines.
13 This represents 26.0% of the pharmacists' total receipts
14 or 0.81% of total retail trade or 0.3783% of the Gross
15 National Product or 0.5486% of Personal Disposable
16 Income. Hence the people of Canada in 1959 spent, on the
17 average, slightly more than one-half a cent on pre-
18 scribed medicines out of every dollar of Personal
19 Disposable Income. The per capita Personal Disposable
20 Income in Canada in 1959 was \$1,367 which means then
21 that the per capita expenditure on prescribed medicines
22 was \$7.49.

23 Similar figures for Ontario would read:
24 In 1959, \$171,316,000 (Bulletin of Retail Trade, Dec.,
25 1959) was spent in Ontario pharmacies, \$23,205,000
26 of which was spent in chain pharmacies and \$148,112,000
27 in independent pharmacies.
28
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1
2 Of this \$171,316,000 spent in retail
3 pharmacies in Ontario \$42,022,833 was spent on pre-
4 scribed medicines. This represents 0.4415% of the
5 Personal Disposable Income of the people of Ontario.
6 The per capita Personal Disposable Income of the people
7 of Ontario was \$1,599 in 1959, higher than the national
8 average, but they spent less than half a cent of each
9 of these dollars on prescribed medicines. Hence the
10 per capita expenditure on prescribed medicines was
11 \$7.06. There were 3.6 persons in an Ontario family
12 in 1959, hence average family expenditure on prescribed
13 medicines was \$25.41.

14 It is the expenditure of the 0.4415% of the
15 Personal Disposable Income of the people of Ontario
16 on prescribed medicines that we are concerned with here.

17 Mark K. Inman, Professor of Economic and
18 Political Science, The University of Western Ontario,
19 in his 1960 book, Economics in a Canadian Setting says,

20 "As resources are scarce on one hand and capable
21 of alternative uses on the other, man is confronted
22 with the problem of making the most effective use
23 of the means at his disposal. He must not only
24 conserve facilities but also choose among the
25 alternative ways in which resources may be
26 employed. Economic wisdom dictates that the
27 most pressing wants should be taken care of first;
28 then resources should be switched to the satis-
29 fying of other desires in the order of their
30



1
2 importance. Only by this procedure can the
3 greatest possible amount of satisfactions be
4 obtained."

5 To ascertain whether the people of Canada
6 spent their money wisely or not, I have produced in
7 Table I on the next page, compiled from the DBS
8 National Accounts, how we spent our money in both 1954
9 and five years later in 1959. We have all heard the
10 word inflation and know that it means that our money
11 does not buy as much as it did at some former time.
12 The government measures these changes by means of Index
13 Numbers, using the year 1949 as a constant. In the
14 table, I have related both the 1954 and the 1959
15 expenditures to Constant Dollars (1949) so that real
16 movement in purchasing will be evident.

17 Whether we look at the figures in current
18 dollars or in constant dollars we find that the average
19 Canadian consumer spent approximately:

20 in 1954

21 6 times as much on tobacco
22 8 times as much on alcoholic beverages
23 5 times as much on radio & television sets
24 10 times as much on automobile operation
25 twice as much on newspapers & magazines
26 more than as much on travelling abroad
27 and SAVED 13 times as much

28 in 1959

29 5 times as much on tobacco
30 6 times as much on alcoholic beverages



1
2 4 times as much on radio & television sets
3 8 times as much on automobile operation
4 more on newspapers and magazines
5 more than as much on travelling abroad
6 and SAVED 14 times as much

7 AS HE SPENT ON PRESCRIBED MEDICINES

8 A few moments ago, I pointed out that in
9 1959 Canadians spent 0.3783% of their GNP on Prescriptions.
10 At the same time the Federal Government spent 0.3584%
11 of the GNP on subsidies to agriculture. Emergency
12 gold mine assistance, maritime freight rates, movement
13 of coal, and miscellaneous subsidies brought the total
14 to 0.5492% of our Gross National Product.

15 DID WE SPEND OUR MONEY WISELY IN 1959?

16 Since the purpose of this submission is to
17 orient pharmaceutical services with the rest of the
18 Canadian economy, a great deal of emphasis must be
19 placed on the dispensing and compounding aspects of
20 the Pharmacist's activities.

21 The pharmacy is a distinct economic institution.
22 It is the dispensing and compounding of prescriptions
23 that makes it different from all other institutions.
24 On the other hand since only 26% (23.2% in Ontario)
25 of the gross receipts of the pharmacy comes from
26 prescriptions, it is more than obvious that the pharmacist
27 engages in other activities. He sells proprietary
28 medicines and household remedies which together con-
29 stitute about 25% of his total receipts. The remaining
30

| PERSONAL EXPENDITURE ON CONSUMER GOODS AND SERVICES 1954 AND 1959 | | | | | | |
|---|---------------------------------------|-------------------------------------|---|---------------------------------------|-------------------------------------|---|
| | 1954 | | Per Capita in Constant Dollars | Total in millions of Dollars | 1959 | |
| | Total in millions of Dollars | Per Capita in 1954 Dollars | | | Per Capita in 1959 Dollars | Per Capita in Constant Dollars |
| FCOD | \$ 4,030 | \$ 263.62 | \$222.46 | \$ 5,401 | \$ 309.65 | \$238.74 |
| TOBACCO & ALCOHOLIC BEVERAGES | 1,114 | 72.87 | 61.49 | 1,555 | 89.15 | 68.73 |
| Tobacco products & smokers' accessories | 461 | 30.16 | 25.44 | 693 | 39.73 | 30.63 |
| Alcoholic beverages | 653 | 42.71 | 36.04 | 862 | 49.42 | 38.10 |
| CLOTHING & PERSONAL FURNISHINGS | 1,826 | 119.44 | 100.79 | 2,258 | 129.45 | 99.80 |
| SHELTER | 2,192 | 143.39 | 120.99 | 3,337 | 191.31 | 147.50 |
| HOUSEHOLD OPERATION | 2,104 | 137.63 | 116.14 | 2,872 | 164.65 | 126.94 |
| Electricity | 191 | 12.49 | 10.54 | 299 | 17.14 | 13.21 |
| Gas | 44 | 2.87 | 2.42 | 93 | 5.33 | 4.10 |
| Telephone | 172 | 11.25 | 9.49 | 293 | 16.79 | 12.94 |
| Appliance, radio & television sets | 412 | 26.95 | 22.74 | 524 | 30.04 | 23.16 |
| TRANSPORTATION | 1,800 | 117.75 | 99.35 | 2,642 | 151.47 | 116.78 |
| New automobiles, used automobiles & house trailers | 859 | 56.19 | 47.41 | 1,229 | 70.46 | 54.32 |
| Automotive operating expenses | 628 | 41.08 | 34.66 | 1,024 | 58.70 | 45.25 |
| PERSONAL & MEDICAL CARE & DEATH EXPENSES | 1,091 | 71.36 | 60.21 | 1,661 | 95.22 | 73.41 |
| MISCELLANEOUS | 2,018 | 132.00 | 111.39 | 2,535 | 145.33 | 112.05 |
| Motion picture theatres | 97 | 6.34 | 5.35 | 68 | 3.89 | 2.99 |
| Newspapers 7 Magazines | 175 | 11.44 | 9.65 | 222 | 12.72 | 9.80 |
| Net Expenditure abroad | 108 | 7.06 | 5.95 | 234 | 13.41 | 10.33 |
| TOTAL SAVED | \$16,175 809 | \$1,058.08 52.92 | \$892.89 44.65 | \$22,261 1,594 | \$1,276.26 91.21 | \$983.99 71.32 |
| PRESCRIPTIONS | | \$ 4.49 | \$ 3.79 | | \$ 7.50 | \$ 5.78 |



1
2 49% of his receipts come from the sale of film candy,
3 tobacco products, sundries of all kinds, magazines and
4 newspapers, cosmetics and toilet articles, ice-cream
5 and toys. Hence when we look at the operating
6 statement of the average pharmacist we must not conclude
7 that either all his receipts are from dispensing and
8 compounding or that all of his total income is derived
9 from such activities.

10 The economic operation of a modern pharmacy
11 is a complex one. As I have said, there is no other
12 institution like it. On the one hand the pharmacist
13 performs professional services to individuals when he
14 dispenses or compounds prescriptions and on the other
15 hand, society not only allows but seems to expect that
16 he must earn a considerable part of his living by
17 engaging in other activities that are non-professional
18 and oftentimes unrelated to his profession.

19 Few pharmacists keep departmentalized
20 accounting records. The teaching of modern accounting
21 methods in the education of the pharmacist has been a
22 very late comer. Until nine years ago, except for a
23 very few sporadic efforts on the part of the DBS no
24 organization attempted to collect data annually con-
25 cerning the operation of the Canadian pharmacy. Nine
26 years ago, under the sponsorship of the Canadian
27 Pharmaceutical Association, I started such an activity.

28 I would like to add here, gentlemen,
29 that the reason I started this, on my return to Canada
30



1 I found there were no available sound statistics that
2 I could use to try to teach the embryonic pharmacist
3 how to run his pharmacy.

4 I was graduated from the Ontario College of
5 Pharmacy in 1921, before my 21st birthday, and taught
6 how to dispense and to work in one of the most outstand-
7 ing prescription pharmacies in Canada, the late A. E.
8 Drawery in Hamilton where we dispensed 100 prescriptions
9 a day the year round, but I had no training in how to
10 run a pharmacy, and several years later I started a
11 pharmacy of my own.

12 Four years later I didn't have it. I felt
13 at the time very bitter against the chain stores and
14 so on, and after living a few years, I learned that at
15 least 50 per cent of the errors were my own because
16 I had lacked in training. So for the last 34 years it
17 has been my position to institute and teach what might
18 be called business subjects in Colleges of Pharmacy
19 in the United States and Canada so that the pharmacist,
20 when he graduates and goes out into the business world,
21 he has some idea as to how much he should pay for rent,
22 how much he should pay for insurance, how much for
23 advertising, what the delivery cost should be, and
24 the telephone bill, and what he should pay for hired
25 help.

26 When I entered it I had no idea what percentage
27 I should pay, what percentage of sales for rent, and
28 I paid about four times as much as I should have, and
29 that was one of the reasons.
30



1 On return to Canada, not having any body of
2 figures, I started out to collect them, and I needed a
3 sponsor to pay the bill, and I sold the idea to the
4 Canadian Pharmaceutical Association, and that was the
5 reason for starting this survey as it is now constituted.
6

7 I might say previous to 1951 a survey was
8 made, but it was a questionnaire survey. The survey
9 was not based on an analysis of the actual operating
10 statements of the pharmacists. The last nine surveys
11 have been accountants' analyses of the operating
12 statements of the pharmacies of Canada.

13 THE CHAIRMAN: Would this be a convenient
14 time to have a five-minute recess?

15 PROF. FULLER: Yes, it would be very nice.

16 ---A short recess.
17
18
19
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25

26 ---(Page 505 follows.)
27
28
29
30



1 PROF. FULLER: The first year 1952 for the
2 year 1951, only 149 pharmacists out of nearly 5,000
3 in Canada were willing to submit their operating state-
4 ments. However, the value of the Annual Survey has
5 increased to the point that now over 500 pharmacists
6 submit their operating statements each year. This
7 represents more than a 10% sample of all retail phar-
8 macies in Canada. Only about 55% of the pharmacists sub-
9 mitting data, submit it in two successive years. Hence,
10 I think it is a very conservative estimate to say that
11 I have examined the operating statements of about 2,000
12 different pharmacies in Canada during the past nine
13 years. Much of the data that follows is from these
14 Annual Surveys. No other organization in Canada collects
15 and analyzes such data annually.

16 We said earlier that consumers spent \$503,351,86
17 (\$171,316,000 in Ontario) of which \$130,871,483
18 (\$42,022,833 in Ontario) represented prescriptions, in
19 Canadian pharmacies in 1959. Since we have asked whether
20 the consumer spends his money WISELY, we might ask if
21 the pharmacist spends his money wisely. What did
22 he do with the \$503,351,861 (\$171,316,000 in Ontario)
23 that consumers spent in pharmacies? Table II, on the
24 next page, shows what the average pharmacist did with
25 his Gross Receipts. This table becomes, in effect,
26 a detailed analysis of the cost of operating an average
27 pharmacy. The Table is based on the arithmetical
28 average compiled from 511 operating statements submitted
29 to the Canadian Pharmaceutical Association in the last
30



1 few months. The table also gives an analyses of 165
2 Ontario pharmacies which were part of the total 511.

3
4 It shows -- and I will read the Ontario
5 figures only that regardless of what the consumer spent
6 his dollar on in the retail pharmacy, whether for
7 toothpaste, tobacco, film, cosmetics or PRESCRIPTIONS,
8 the pharmacist spent it in the following way:

| 511 Canadian Pharmacies | 165 Ontario Pharmacies |
|--|---------------------------|
| 66.8 cents was paid to wholesalers and suppliers | 66.9 cents |
| 8.4 cents was paid to the proprietor as salary or to the manager if it was a limited company | 8.7 cents |
| 9.6 cents was paid to employees for wages | 9.3 cents |
| 2.5 cents was paid to the landlord for rent | 2.4 cents |
| 1.1 cents was paid for advertising | 1.0 cents |
| 0.8 cents was paid for the cost of delivery | 0.9 cents |
| 1.2 cents was paid for depreciation on fixtures and equipment | 1.3 cents |
| 0.7 cents was paid for heat, light, and power | 0.6 cents |
| 0.3 cents was paid for taxes | 0.3 cents |
| 0.4 cents was paid for insurance | 0.5 cents |
| 0.4 cents was paid for interest on borrowed money | 0.3 cents |
| 0.4 cents was paid for repairs | 0.4 cents |
| 0.3 cents was paid for telephone | 0.3 cents |
| 0.1 cents was paid to write off bad debts of customers | 0.1 cents |
| 1.8 cents was paid for miscellaneous expenses | 1.6 cents |



511 Canadian
Pharmacies

165 Ontario
Pharmacies

LEAVING

5.2 cents to the owners as profit
(before taxes)

5.4 cents

46.0% of the 38.1% of the
511 Pharmacies were limited companies or 165 Pharmacies
partnerships and hence the
total net profit did not
necessarily go to the pharmacist-manager in addition
to his salary.

MR. SUTTON: What are these figures? Are
they for 1960 as against Table II?

PROF. FULLER: This is Page 8 of the
statement that has just been given to you, not the
printed one. Returning to the bottom of page 7,
Table III, following Table II, permits a comparison
of 1959 with each or all of the previous eight years.
This is for Canada as a whole. There just was not
time to go back over nine years' statistics and
we give figures for Ontario alone.

You will notice that the average net profit
for the past nine years has been almost an even 5%
of sales. Out of every dollar spent in a pharmacy five
cents was a return on the necessary investment
to maintain economic institutions called pharmacies
so that society would be provided with "health
stations", as it were, to supply people with the



medicinals and prescription accessories recommended by the medical profession. That brings us to page 10.

We can have some estimate of the economic efficiency of pharmacies 1) by looking at their profits and losses, remembering that no economic institution in our society can remain a going concern unless it makes a profit over time.

On page 7, I said that the average net profit for the past nine years has been almost an even 5% of sales. Not half of our pharmacies earned that much in 1959. In fact 51.5% sustained losses or earned less than 5% of sales. A summary of the distribution of profits and losses is given in the following schedule.

I do not think you wish me to read that.

I would like to read that 165 Ontario Pharmacies in 1959, 12.7% operated at a loss, another 28.5% at a profit below 5% of sales, and 43% at a profit between 5 and 10%, and 15.8% above 10% of sales.

| Year | LOSS | Profit Below 5% of Sales | Profit 5% to 10% of Sales | Profit over 10% of Sales |
|--------------------------------|-------|-----------------------------|------------------------------|-----------------------------|
| 1955 | 24.9% | | | |
| 1956 | 17.9% | 45.3% | 26.4% | 10.4% |
| 1957 | 12.0% | 46.2% | 30.6% | 11.2% |
| 1958 | 11.4% | 47.1% | 27.4% | 14.1% |
| 1959 | 14.5% | 37.0% | 31.3% | 17.2% |
| <hr/> | | | | |
| | 12.7% | 28.5% | 43.0% | 15.8% |
| 165 Ontario Pharmacies in 1959 | | | | |

Of the 165 Ontario pharmacies reporting for 1959, 51 or 30.9% paid out less than \$100.00 a week as wages

TABLE III

WHAT THE PHARMACIST DID WITH THE CONSUMER'S DOLLAR

| | <u>1959</u> | <u>1958</u> | <u>1957</u> | <u>1956</u> | <u>1955</u> | <u>1954</u> | <u>1953</u> | <u>1952</u> | <u>1951</u> |
|----------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Paid to Wholesalers & Suppliers | 66.8¢ | 67.5¢ | 67.5¢ | 67.9¢ | 68.5¢ | 69.0¢ | 69.0¢ | 70.4¢ | 70.1¢ |
| Proprietor's or Manager's Salary | 8.4¢ | 8.2¢ | 8.1¢ | 8.4¢ | 8.1¢ | 7.8¢ | 7.5¢ | 6.7¢ | 6.0¢ |
| Employees' Wages | 9.6¢ | 9.8¢ | 9.8¢ | 9.6¢ | 9.7¢ | 9.1¢ | 9.4¢ | 7.6¢ | 8.5¢ |
| Rent | 2.5¢ | 2.4¢ | 2.4¢ | 2.4¢ | 2.5¢ | 2.4¢ | 2.3¢ | 2.2¢ | 2.2¢ |
| Advertising | 1.1¢ | 1.1¢ | 1.1¢ | 1.1¢ | 1.1¢ | 1.0¢ | 1.1¢ | 0.9¢ | 1.0¢ |
| Delivery | 0.8¢ | 0.8¢ | 0.7¢ | 0.8¢ | 0.7¢ | 0.7¢ | 0.6¢ | 0.5¢ | 0.5¢ |
| Depreciation | 1.2¢ | 1.2¢ | 1.4¢ | 1.0¢ | 0.9¢ | 1.0¢ | 0.9¢ | 0.9¢ | 0.7¢ |
| Heat, Light, Power | 0.7¢ | 0.7¢ | 0.7¢ | 0.8¢ | 0.8¢ | 0.7¢ | 0.7¢ | 0.7¢ | 0.7¢ |
| Taxes | 0.3¢ | 0.3¢ | 0.4¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ |
| Insurance | 0.4¢ | 0.4¢ | 0.4¢ | 0.4¢ | 0.5¢ | 0.4¢ | 0.4¢ | 0.5¢ | 0.5¢ |
| Interest on borrowed Money | 0.4¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.2¢ | 0.3¢ | 0.3¢ |
| Repairs | 0.4¢ | 0.5¢ | 0.4¢ | 0.5¢ | 0.4¢ | 0.4¢ | 0.4¢ | 0.3¢ | 0.4¢ |
| Telephone | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ | 0.3¢ |
| Bad Debts | 0.1¢ | 0.1¢ | 0.1¢ | 0.1¢ | 0.1¢ | 0.1¢ | 0.1¢ | 0.1¢ | 0.1¢ |
| Miscellaneous Expenses | 1.8¢ | 1.8¢ | 1.7¢ | 1.6¢ | 1.8¢ | 2.0¢ | 1.9¢ | 1.5¢ | 2.3¢ |
| Net Profit to Owners | 5.2¢ | 4.7¢ | 5.1¢ | 4.5¢ | 4.0¢ | 4.5¢ | 4.9¢ | 6.8¢ | 6.2¢ |
| | 100.0¢ | 100.0¢ | 100.0¢ | 100.0¢ | 100.0¢ | 100.0¢ | 100.0¢ | 100.0¢ | 100.0¢ |



1 which means that the proprietors worked long hours, of-
2 times between 60 and 72 hours per week, since the law
3 requirs a pharmacist to be on duty at all times when a
4 pharmacy is open. These Ontario pharmacists earned
5 as TOTAL INCOME, that is proprietor's salary plus net
6 profit, an average of \$9,183 or about \$3.00 an hour
7 for the privilege of working, managing and OWNING.
8

9 I might add here that I went to the original
10 replies of each Ontario pharmacy for the periods listed
11 and took that out on a calculating machine last week:

12 2) by comparing their operating costs and profits
13 with other institutions that, in some cases, sell some
14 of the same things (except prescriptions) that
15 pharmacies sell. Since approximately 75% of the total
16 receipts of pharmacies come from selling things bought by
17 customers on their own initiative and 85% of these things
18 are sold by other retailers, pharmacies must compete
19 with these others in economic efficiency else the public
20 would buy these things elsewhere.

21 Comparisons are often difficult for a
22 number of reasons. The chief source of information
23 about others is the Dominion Bureau of Statistics.
24 Every two years the Bureau makes a study of the
25 Operating Results and Financial Structure of a wide
26 variety of stores. About two years later the studies get
27 published with the result that we have studies of ten types
28 of retail establishments for 1958 and eight others for
29 1956 (the 1958 studies for these eight have not been
30 published yet).



1
2 Also, in the 1958 studies, the ratios are
3 "weighted" according to the 1951 Census weights of the
4 different sales sizes for independent stores. Our
5 Canadian Pharmaceutical Association Surveys are NOT
6 weighted hence comparisons are difficult.

7 Further, the DBS classifies independent stores
8 (non-chain) as unincorporated and incorporated. As a
9 result proprietors' salaries in the unincorporated
10 group are included in "net profit" while in the
11 incorporated group proprietors' salaries are included
12 in operating expenses. It becomes impossible in the
13 incorporated group to find the proprietor's salary
14 and add it to his net profit in order to discover his
15 TOTAL INCOME. In our C.ph.A. studies, unincorporated
16 and incorporated pharmacies are not separated. We
17 obtain TOTAL INCOME for a pharmacy (not a pharmacist) by
18 adding the proprietor's or manager's salary to the net
19 profit. That becomes the total income of his business
20 unit, taking it on the assumption that one man owns it.

21 Table IV gives the gross margin, both
22 unincorporated and incorporated, and the net profit
23 before deduction of the proprietor's salary and
24 income taxes for unincorporated only, of 18 types
25 of retail establishments in these DBS studies. Gross
26 Margin in pharmacies is slightly higher than in other
27 establishments, with the exception of jewellery,
28 restaurants, and family shoe stores, and it should be
29 because it reflects the prescription and professional
30 activities of the pharmacist.

12
TABLE IV

| Type of Retail Establishment | Gross Margin | Net Profit |
|---|--------------|------------|
| Men's Clothing Stores - Unincorporated - 1958 | 28.55% | 10.39% |
| Incorporated | 30.89 | |
| Women's Clothing Stores - Unincorporated - 1958 | 28.78 | 8.52 |
| Incorporated | 31.91 | |
| Family Clothing Stores - Unincorporated - 1958 | 27.12 | 8.45 |
| Incorporated | 30.55 | |
| Family Shore Stores - Unincorporated - 1958 | 29.31 | 11.19 |
| Incorporated | 33.21 | |
| Grocery Stores - Unincorporated - 1958 | 15.07 | 5.89 |
| Combination (Grocery & Fresh Meats) - Unincorporated - 1958 | 15.07 | 4.41 |
| Meat Markets - Unincorporated - 1958 | 19.07 | 6.12 |
| Confectionery Stores - Unincorporated - 1958 | 19.15 | 7.47 |
| Fruit & Vegetable Stores - Unincorporated | 19.00 | 6.51 |
| General Stores - 1958 | 14.81 | 5.78 |
| Fuel Dealers - Unincorporated - 1956 | 21.12 | 5.43 |
| Incorporated | 22.13 | |
| Hardware - Unincorporated - 1956 | 25.79 | 9.36 |
| Incorporated | 26.92 | |
| Furniture Stores - Unincorporated - 1956 | 26.08 | 8.29 |
| Incorporated | 27.95 | |
| Household Appliance, Radio & Television - Unincorporated | 25.62 | 7.35 |
| Incorporated - 1956 | 25.50 | |
| Jewellery Stores - Unincorporated - 1956 | 40.83 | 15.98 |
| Incorporated | 44.23 | |
| Restaurants - 1956 | 40.77 | 8.63 |
| Tobacco Stores - 1956 | 18.69 | 7.91 |
| Drug Stores - Unincorporated - 1956 | 30.26 | 12.12 |
| Incorporated | 32.76 | |

This report on operating results and financial structure presents information in the form of averages and ratios as a guide to retail store operators for the trade covered here. These ratios are the "average" of a broad range of operational efficiency, and as such do not represent top performance guides. However, used with this in mind, they show a standard by which business men can compare their own operating experiences. from the Introduction to Operating Results and Financial Structure Independent Drug Stores, 1956 - DBS.

Note also "These ratios are weighted" according to the 1951 Census weights of the different sales sizes for independent stores. They do not agree with ratios shown in historical tables."

| | | |
|--|-----------------------|-------|
| Pharmacies - 511 Respondents - C.Ph.A. 1959 Survey | | |
| | Unweighted | 33.2% |
| | Weighted | 32.4% |
| 149 - Unincorporated - Rented - 1959 | | |
| by Sales Volume - Unweighted | | |
| From 18th | \$Below \$50,000 | 31.7% |
| Annual | \$50,000 - \$ 75,000 | 33.2% |
| C.Ph.A. | \$75,000 - \$100,000 | 32.4% |
| Survey | \$100,000 - \$150,000 | 33.0% |
| C.Ph.J.- | Over \$150,000 | 34.6% |
| Sept., 1960 | | 11.1% |



1 Table V gives the average sales in 18 types
2 of retail establishments - unincorporated only. If we
3 multiply the average sales by the net profit ratio we
4 get the proprietor's net profit before deducting his
5 own withdrawals and his income tax. This is a com-
6 parable figure to what we call TOTAL INCOME in our
7 Canadian Pharmaceutical Association studies.

8 A glance at this table tells us that the
9 proprietors of men's clothing, family clothing, family
10 shoe, and furniture stores received a larger compensa-
11 tion from society for their services than the pharmacist
12 with his scientific and professional four years of
13 university training.
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29 --- (Page 514 follows.)
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TABLE V

Type of Retail Establishment

| <u>Unincorporated</u> 1958 - "weighted" | Number of Stores | Average Sales | (Average Sales of Corporate Counterpart) | Net * Profit | Average * Net Profit |
|---|---------------------|------------------|---|-----------------|----------------------------|
| Men's Clothing | 401 | \$ 84,405 | (\$167,135 - 219) | 11.14% | \$9,404 |
| Women's Clothing | 317 | \$ 67,692 | (\$184,930 - 109) | 9.09% | \$6,153 |
| Family Clothing | 209 | \$100,140 | (\$320,820 - 106) | 9.62% | \$9,633 |
| Family Shoe | 300 | \$ 72,986 | (\$133,559 - 106) | 11.84% | \$8,641 |
| Grocery Stores | 728 | \$ 58,541 | | 6.54% | \$3,828 |
| Combination Stores | 880 | \$115,608 | | 4.82% | \$5,572 |
| Meat Markets | 232 | \$102,500 | | 6.64% | \$6,806 |
| Confectionery | 181 | \$ 30,207 | | 8.11% | \$2,450 |
| Fruit and Vegetable | 144 | \$ 68,377 | | 7.01% | \$4,793 |
| General | 609 | \$ 84,395 | | 6.19% | \$5,224 |
| <u>1956 - Unweighted</u> | | | | | |
| Fuel | 176 | \$ 98,792 | | 6.84% | \$6,757 |
| Hardware | 448 | \$ 53,137 | | 11.11% | \$5,903 |
| Furniture | 151 | \$ 91,526 | | 9.39% | \$8,594 |
| Household Appliances, 116 Radio & Television | | \$ 87,153 | | 8.43% | \$7,347 |
| Jewellery | 387 | \$ 33,063 | | 17.81% | \$5,888 |
| Restaurants | 309 | \$ 62,497 | | 8.96% | \$5,600 |
| Tobacco | 240 | \$ 41,742 | | 8.74% | \$3,648 |
| Drug Stores | 517 | \$ 63,956 | | 13.03% | \$8,333 |

* Net Profit before deduction of proprietors' salaries and income tax



Prescriptions and Prescription Prices

Prescription receipts in Canadian pharmacies in 1959 were the highest on record, 26.0% (Ontario 23.2%) of total receipts. This does not mean that the price of prescriptions has gone up by any large amount. Much of the increase results simply from an increase in use. It is much like saying that electric and electronic inventions have increased the number of different appliances that the consumer can now spend his money on such as transistor radios and colour television and the increase in the number of different kinds of electrical equipment increases the use of electricity and hence the average electric bill. Many of the medicinals used widely today could not have been purchased at any price ten years ago.

In the 1960 Canadian Pharmaceutical Survey, published in the September issue of the Canadian Pharmaceutical Journal, 315 or 62% of the 511 respondents recorded prescription data. The next three pages are reproductions of the operating ratios of these 315 Canadian pharmacies, classified according to the ratio of Prescription Receipts to Total Receipts, that is 10% to 20% of Sales, 20% to 30% of Sales, 30% to 40% of Sales and Over 40% of Sales. Ontario pharmacies reporting prescription data likewise given to similar fashion.

I would like to repeat that TOTAL INCOME, that is Proprietor's Salary plus Other Income from telephone booths, vending machines, commissions, post-offices, etc., plus Net Profit does not



1 necessarily accrue to one person since 46.0% of the
2 511 Canadian pharmacies and 38.1% of the Ontario
3 pharmacies in the Survey are limited companies or
4 partnerships. And further, since approximately 75%
5 of Sales are from other things than prescriptions,
6 only a small part of the Net Profit can be attributed
7 to the operation of the Prescription Department.

8 Pages 16, 17 and 18 are reproductions of
9 charts from the profit survey, that I see all members
10 of the Committee have before them. I did not know
11 that you would have them, otherwise I would not have
12 had them mimeographed.

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23 --- (Page 517 follows.)
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| | 315 Pharmacies Reporting Rx Receipts | 116 Pharmacies with Rx Receipts 10% to 20% of Total Receipts | 103 Pharmacies with Rx Receipts 20% to 30% of Total Receipts |
|---|--|---|---|
| Sales | \$106,552 - 100.0% | \$121,900 - 100.0% | \$93,945 - 100.0% |
| Cost of Goods Sold | 70,751 - 66.4% | 82,892 - 68.0% | 63,413 - 67.5% |
| Gross Margin | 35,801 - 33.6% | 39,008 - 32.0% | 30,532 - 32.5% |
| EXPENSES: | | | |
| Proprietor's or Manager's Salary | \$ 8,631 - 8.1% | \$ 8,777 - 7.2% | \$ 7,797 - 8.3% |
| Employees' Wages | 10,975 - 10.3% | 13,653 - 11.2% | 8,643 - 9.2% |
| Rent | 2,664 - 2.5% | 3,413 - 2.8% | 2,161 - 2.3% |
| Advertising | 1,172 - 1.1% | 1,463 - 1.2% | 939 - 1.0% |
| Delivery | 746 - 0.7% | 853 - 0.7% | 658 - 0.7% |
| Depreciation on Fixtures | 1,278 - 1.2% | 1,341 - 1.1% | 1,127 - 1.2% |
| Heat, Light, Power | 746 - 0.7% | 1,097 - 0.9% | 658 - 0.7% |
| Taxes | 426 - 0.4% | 366 - 0.3% | 376 - 0.4% |
| Insurance | 426 - 0.4% | 366 - 0.3% | 376 - 0.4% |
| Interest | 533 - 0.5% | 731 - 0.6% | 563 - 0.6% |
| Repairs | 533 - 0.5% | 731 - 0.6% | 376 - 0.4% |
| Telephone | 320 - 0.3% | 366 - 0.3% | 282 - 0.3% |
| Bad Debts | 106 - 0.1% | 122 - 0.1% | 94 - 0.1% |
| Miscellaneous | 2,024 - 1.9% | 2,072 - 1.7% | 1,973 - 2.1% |
| Total Expenses | \$30,580 - 28.7% | \$35,351 - 29.0% | \$26,023 - 27.7% |
| NET PROFIT | \$ 5,221 - 4.9% | \$ 3,657 - 3.0% | \$ 4,509 - 4.8% |
| Add: Other Income | \$ 625 | \$ 978 | \$ 437 |
| Proprietor's Salary | \$ 8,631 | \$ 8,777 | \$ 7,797 |
| TOTAL INCOME | \$14,477 | \$13,412 | \$12,743 |
| Value of Merchandise Stock | \$20,221 | \$21,936 | \$19,060 |
| Annual Rate of Turnover | 3.6 | 3.8 | 3.5 |
| Average Value of Fixtures | \$ 6,230 | \$ 7,481 | \$ 5,334 |
| Average Accounts Receivable | \$ 2,538 | \$ 2,457 | \$ 2,181 |
| Average Accounts Payable | \$ 5,126 | \$ 4,035 | \$ 6,019 |
| Average Price per Prescription | \$ 2.98 | \$ 3.12 | \$ 2.97 |
| Average Number of Prescriptions | 9,284 | 6,855 | 7,954 |
| Average Receipts from Prescriptions | \$27,732 | \$21,390 | \$23,648 |
| Ratio of Prescription Receipts to Total Receipts | 26.0% | 17.5% | 25.1% |

| | 63 Pharmacies with Rx Receipts 30% to 40% of Total Receipts | 33 Pharmacies with Rx Receipts Over 40% of Total Receipts |
|---|--|--|
| Sales | \$102,420 - 100.0% | \$99,629 - 100.0% |
| Cost of Goods Sold | 66,163 - 64.6% | 60,674 - 60.9% |
| Gross Margin | 36,257 - 35.4% | 38,955 - 39.1% |
| EXPENSES | | |
| Proprietor's or Manager's Salary | \$ 8,398 - 8.2% | \$10,162 - 10.2% |
| Employees' Wages | 10,447 - 10.2% | 10,959 - 11.0% |
| Rent | 2,356 - 2.3% | 2,690 - 2.7% |
| Advertising | 1,229 - 1.2% | 1,096 - 1.1% |
| Delivery | 819 - 0.8% | 897 - 0.9% |
| Depreciation on Fixtures | 1,332 - 1.3% | 995 - 1.0% |
| Heat, Light, Power | 615 - 0.6% | 399 - 0.4% |
| Taxes | 410 - 0.4% | 299 - 0.3% |
| Insurance | 512 - 0.5% | 399 - 0.4% |
| Interest | 410 - 0.4% | 199 - 0.2% |
| Repairs | 410 - 0.4% | 199 - 0.2% |
| Telephone | 307 - 0.3% | 399 - 0.4% |
| Bad Debts | 102 - 0.1% | 99 - 0.1% |
| Miscellaneous | 2,048 - 2.0% | 2,192 - 2.2% |
| Total Expenses | \$29,395 - 28.7% | \$30,985 - 31.1% |
| NET PROFIT | \$ 6,862 - 6.7% | \$ 7,970 - 8.0% |
| Add: Other Income | \$ 467 | \$ 261 |
| Proprietor's Salary | \$ 8,398 | \$10,162 |
| TOTAL INCOME | \$15,727 | \$18,393 |
| Value of Merchandise Stock | \$20,941 | \$16,253 |
| Annual Rate of Turnover | 3.3 | 3.5 |
| Average Value of Fixtures | \$ 6,667 | \$ 4,778 |
| Average Accounts Receivable | \$ 3,299 | \$ 2,335 |
| Average Accounts Payable | \$ 6,253 | \$ 4,592 |
| Average Price per Prescription | \$ 2.91 | \$ 2.90 |
| Average Number of Prescriptions | 11,820 | 17,322 |
| Average Receipts from Prescriptions | \$34,452 | \$50,385 |
| Ratio of Prescription Receipts to Total Receipts | 33.8% | 50.5% |

| | 30 Pharmacies 10% to 20% of Total Receipts | 25 Pharmacies 20% to 30% of Total Receipts | 11 Pharmacies 30% to 40% of Total Receipts | 4 Pharmacies Over 40% of Total Receipts |
|---|--|--|--|---|
| Sales | \$98,189 - 100.0% | \$108,781 - 100.0% | \$128,202 - 100.0% | \$66,313 - 100.0% |
| Cost of Goods Sold | 67,358 - 68.6% | 72,339 - 66.5% | 79,485 - 62.0% | 42,971 - 64.8% |
| Gross Margin | 30,831 - 31.4% | 36,442 - 33.5% | 48,717 - 38.0% | 23,342 - 35.2% |
| EXPENSES | | | | |
| Proprietor's or Manager's Salary | \$ 8,150 - 8.3% | \$ 9,573 - 8.8% | \$10,897 - 8.5% | \$ 9,615 - 14.5% |
| Employees' Wages | 8,346 - 8.5% | 10,769 - 9.9% | 17,564 - 13.7% | 4,775 - 7.2% |
| Rent | 2,160 - 2.2% | 2,502 - 2.3% | 3,718 - 2.9% | 2,255 - 3.4% |
| Advertising | 884 - 0.9% | 1,197 - 1.1% | 1,410 - 1.1% | 862 - 1.3% |
| Delivery | 589 - 0.6% | 1,088 - 1.0% | 1,282 - 1.0% | 729 - 1.1% |
| Depreciation on Fixtures | 1,276 - 1.3% | 1,197 - 1.1% | 1,795 - 1.4% | 1,194 - 1.8% |
| Heat, Light, Power | 589 - 0.6% | 435 - 0.4% | 513 - 0.4% | 265 - 0.4% |
| Taxes | 295 - 0.6% | 326 - 0.3% | 513 - 0.4% | 133 - 0.2% |
| Insurance | 393 - 0.4% | 544 - 0.5% | 641 - 0.5% | 332 - 0.5% |
| Interest | 589 - 0.6% | 326 - 0.3% | 256 - 0.2% | 265 - 0.4% |
| Repairs | 295 - 0.3% | 435 - 0.4% | 385 - 0.3% | 133 - 0.2% |
| Telephone | 295 - 0.3% | 326 - 0.3% | 513 - 0.4% | 597 - 0.9% |
| Bad Debts | 98 - 0.1% | 109 - 0.1% | 256 - 0.2% | 66 - 0.1% |
| Miscellaneous | 1,374 - 1.4% | 1,958 - 1.8% | 2,436 - 1.9% | 1,458 - 2.2% |
| Total Expenses | \$25,333 - 25.8% | \$30,785 - 28.3% | \$42,179 - 32.9% | \$22,679 - 34.2% |
| NET PROFIT | \$ 5,498 - 5.6% | \$ 5,657 - 5.2% | \$ 6,538 - 5.1% | \$ 663 - 1.0% |
| Add; Other Income | \$ 210 | \$ 401 | \$ 784 | \$ 420 |
| Proprietor's Salary | \$ 8,150 | \$ 9,573 | \$10,897 | \$ 9,615 |
| TOTAL INCOME | \$13,858 | \$15,631 | \$18,219 | \$10,698 |
| Value of Merchandise Stock | \$18,062 | \$20,186 | \$22,447 | \$11,726 |
| Annual Rate of Turnover | 3.6 | 3.6 | 3.5 | 3.7 |
| Average Value of Fixtures | \$ 7,026 | \$ 5,329 | \$ 8,974 | \$ 5,381 |
| Average Accounts Receivable | \$ 5,372 | \$ 1,768 | \$ 4,356 | \$ 1,046 |
| Average Accounts Payable | \$ 1,618 | \$10,920 | \$ 5,418 | \$ 7,176 |
| Average Price per Prescription | \$ 3.09 | \$ 3.30 | \$ 3.20 | \$ 3.26 |
| Average Number of Prescriptions | 4,878 | 8,268 | 13,049 | 8,362 |
| Average Receipts from Prescriptions | \$15,088 | \$27,294 | \$41,806 | \$27,169 |
| Ratio of Prescription Receipts to Total Receipts | 15.3% | 25.0% | 32.6% | 41.1% |



Instead of arranging the date according to the percentage of Prescription Receipts to Total Receipts there are other ways of arrangement that reveal different facts. Arranged as follows we discover that an increase in the NUMBER of prescriptions dispensed increases operating costs. Since operating costs would be arbitrarily increased by proprietors increasing their own salaries total expenses in the following table DO NOT include proprietor's salary:

| Number of Pharmacies | Number of Prescriptions Dispensed | Gross Margin | Total Expenses Excluding Proprietor's Salary |
|----------------------|-----------------------------------|--------------|--|
|----------------------|-----------------------------------|--------------|--|

Prescription Receipts 20% to 30% of Total Receipts

Sales Volume

| | | | | |
|-----------------------|----|--------|-------|-------|
| Under \$50,000 | 11 | 3,371 | 32.2% | 16.1% |
| \$50,000 - \$75,000 | 26 | 5,501 | 32.8% | 18.0% |
| \$75,000 - \$100,000 | 34 | 7,575 | 32.0% | 19.9% |
| \$100,000 - \$150,000 | 20 | 9,434 | 32.5% | 21.0% |
| Over \$150,000 | 12 | 16,084 | 33.6% | 20.8% |

Prescription Receipts 30% to 40% of Total Receipts

| | | | | |
|-----------------------|----|--------|-------|-------|
| Under \$50,000 | 4 | 4,548 | 34.6% | 15.4% |
| \$50,000 - \$75,000 | 13 | 7,588 | 35.1% | 18.0% |
| \$75,000 - \$100,000 | 19 | 10,751 | 34.5% | 20.5% |
| \$100,000 - \$150,000 | 20 | 13,115 | 36.3% | 23.2% |
| Over \$150,000 | 7 | 23,048 | 36.8% | 20.9% |

Prescription Receipts Over 40% of Total Receipts

| | | | | |
|-----------------------|----|--------|-------|-------|
| Under \$50,000 | 3 | 8,100 | 41.3% | 16.9% |
| \$50,000 - \$75,000 | 14 | 11,059 | 37.7% | 18.4% |
| \$75,000 - \$100,000 | 6 | 16,147 | 38.7% | 19.1% |
| \$100,000 - \$150,000 | 6 | 22,705 | 40.8% | 26.5% |
| Over \$150,000 | 3 | 47,318 | 40.8% | 29.5% |



1
2 As the pharmacist dispenses more prescriptions,
3 as his professional activities increase in relationship
4 to his other activities, his expenses increase, and
5 hence his gross margin must increase. As a consequence
6 of the very professional nature of the pharmacist's
7 activities, he can hardly be compared at all with the
8 other types of retailers mentioned above.

9 We can compare gross margins of various types
10 of establishments, shoe stores versus grocery stores.
11 But gross margin is no way to compare the professional
12 services of a pharmacist with the value of a tradesman's
13 services.

14 Just reflecting the previous speaker we could
15 hardly hope to set the professional fees of the dentists
16 as a percentage markup on the cost of the ingredients
17 that he used in filling the tooth and making a denture.

18 A prescription IS NOT TRADE GOODS. It is
19 written by a physician and dispensed by a pharmacist for
20 a PARTICULAR patient who cannot in turn sell it. The
21 cost of dispensing a prescription is not a function,
22 that is the result of, the cost of the ingredients in
23 a prescription.

24 It costs \$2.00 a ton to unload a freighter
25 in the port of Montreal. It doesn't matter what is
26 being unloaded, the cost is \$2.00 a ton. It costs just
27 as much to unload a ton of cotton as a ton of diamonds
28 and the cost of unloading has no relationship,
29 functionally, to the cost of either the cotton or the
30 diamonds. I do not like comparing the dispensing of a



1
2 prescription with the unloading of a freighter but it
3 does cost the pharmacist just as much - that is over-
4 head expenses - to dispense two dozen quarter-grain
5 phenobarbital tablets as two dozen of an expensive
6 antibiotic capsule. He must maintain complete stocks
7 of all modern medicinals and maintain a professional staff.
8 He must have a standard return on this investment since
9 it is a standard transaction cost. He does not know
10 in advance whether a prescription will call for
11 phenobarbital or an antibiotic or a tranquilizer
12 anymore than the crane operator knows in advance, or
13 cares, whether the crane is lifting a ton of cotton or
14 a ton of diamonds. The investment in the crane and
15 the operators time are the same in both cases. And so
16 it is that the investment, the total investment is the
17 same whether the prescription be phenobarbital or
18 aureomycin.

19 Traditionally, however, the pharmacist has sought
20 to recover his overhead costs by some sort of a gross
21 margin on the cost of the ingredients in a prescription.
22 In recent years, both in Canada and the United States,
23 pharmacists are beginning to realize the fallaciousness
24 of this method.

25 In the latter part of 1957 and the early part
26 of 1958, I analyzed 42,545 prescriptions dispensed in
27 Canada during the first sixteen days of November 1957.
28 The method of finding break-even cost was adding 91 cents
29 to the cost of the ingredients. The ninety-one cents
30



1
2 represented 10¢ for the cost of the container, 56¢ for
3 cost-of-labour, and 25¢ for overhead expenses other
4 than labour. The prescriptions were classified at 50¢
5 intervals of selling price. The analysis revealed that
6 46.3% of these 42,545 prescriptions were dispensed at an
7 out-of-pocket LOSS.

8 The tables that follow are reproductions of
9 tables appearing in the Canadian Pharmaceutical Journal
10 and the Bulletin of the Ontario College of Pharmacy in
11 1958. A considerable variation among the provinces will
12 be noticed, for example, 41.3% of the prescriptions
13 dispensed in Ontario, 55% of the prescriptions dispensed
14 in Saskatchewan, and 64% of the prescriptions dispensed
15 in Prince Edward Island were dispensed at a LOSS.
16 Variations in prescription prices among the provinces
17 are the result of a variety of different factors, among
18 them, the prescribing habits of physicians and the number
19 of specialists in each province, 36% of the total
20 physicians in Ontario are specialists, 27% of the total
21 physicians in Quebec.

22 To say that the average prescription price in
23 Canada was \$2.98 in 1959 does not tell us very much.
24 It is the distribution at 50¢ levels that reveals more
25 of the truth.

26 The analysis of the 42,545 prescriptions
27 revealed the following, I will read the Ontario figures
28 only.
29
30



| <u>Canada</u> | <u>Ontario</u> | |
|---------------|----------------|---|
| 46.3% | 41.3% | of prescriptions are priced at \$2.00 |
| | | or less. This is a cumulative percent |
| | | as we go along. |
| 58.8% | 65.2% | of prescriptions are priced at \$3.00 |
| | | or less |
| 81.7% | 79.4% | of prescriptions are priced at \$4.00 |
| | | or less |
| 88.6% | 87.1% | of prescriptions are priced at \$5.00 |
| | | or less |
| 98.9% | 98.8% | of prescriptions are priced at less |
| | | than \$10.00 |
| 1.1% | 1.2% | of prescriptions are priced above \$10.00 |

THE CHAIRMAN: To understand that table at the foot of Page 22, those figures are inclusive of all of the categories below?

PROF. FULLER: That is right. It is cumulative as we go along, and Page 23 is a chart there, the third column gives an accumulative per cent at each 50 cent interval, as we go along, and on Page 24, we have the same thing by provinces, and the fourth to the last column is Ontario, and there is an accumulative per cent at each 50 cent interval as we go along, and it is from that column that I devised the abbreviated synopsis on the bottom of Page 21.

Then Page 25 gives it for Ontario alone; a little different fashion; that brings us to Page 26.



CANADIAN PRESCRIPTION SURVEY - 1957

| Province | Number of Particip- ants | Number of Prescrip- tions | Gross Margin | Average Cost of Ingred- ients | Average Price |
|-------------------------|--------------------------------|---------------------------------|-----------------|-------------------------------------|------------------|
| Prince Edward Island | 7 | 1,725 | 44.6% | \$1.20 | \$2.17 |
| Nova Scotia | 6 | 1,582 | 47.8% | 1.34 | 2.56 |
| New Brunswick | 1 | 399 | 54.7% | 1.13 | 2.50 |
| Quebec | 3 | 470 | 49.2% | 1.38 | 2.71 |
| Ontario | 117 | 25,565 | 50.0% | 1.51 | 3.03 |
| Manitoba | 14 | 3,493 | 47.8% | 1.27 | 2.44 |
| Saskatchewan | 21 | 6,354 | 43.1% | 1.45 | 2.55 |
| Alberta | 13 | 2,957 | 51.5% | 1.34 | 2.77 |
| TOTAL | 182 | 42,545 | 48.8% | 1.45 | 2.82 |

42,545 Prescriptions from 182 Pharmacies

Fuller

525

| Price Range | of Total Prescriptions | Cumulative Per Cent | Gross Margin % | Gross Margin \$ | Average Cost of Ingredients | Average Price | Break-Even Cost |
|------------------|------------------------|---------------------|----------------|-----------------|-----------------------------|---------------|---------------------|
| \$0.01 - \$ 0.50 | 0.7% | | 59.4% | \$0.27 | \$0.19 | \$0.46 | \$1.10 ^a |
| 0.51 - 1.00 | 10.4% | 11.1% | 58.5% | 0.52 | 0.37 | 0.89 | 1.28 ^a |
| 1.01 - 1.50 | 17.9% | 29.0% | 59.5% | 0.90 | 0.45 | 1.35 | 1.36 ^a |
| 1.51 - 2.00 | 17.3% | 46.3% | 55.6% | 1.01 | 0.81 | 1.82 | 1.72 ^a |
| 2.01 - 2.50 | 12.2% | 58.5% | 52.8% | 1.22 | 1.10 | 2.32 | 2.01 |
| 2.51 - 3.00 | 10.3% | 68.8% | 50.2% | 1.41 | 1.40 | 2.81 | 2.31 |
| 3.01 - 3.50 | 6.9% | 75.7% | 48.9% | 1.64 | 1.72 | 3.36 | 2.63 |
| 3.51 - 4.00 | 6.0% | 81.7% | 46.9% | 1.79 | 2.03 | 3.82 | 2.94 |
| 4.01 - 4.50 | 3.8% | 85.5% | 44.9% | 1.95 | 2.38 | 4.33 | 3.29 |
| 4.51 - 5.00 | 3.1% | 88.6% | 44.5% | 2.15 | 2.67 | 4.82 | 3.58 |
| 5.01 - 5.50 | 2.0% | 90.6% | 43.4% | 2.32 | 3.04 | 5.36 | 3.95 |
| 5.51 - 6.00 | 2.7% | 93.3% | 42.9% | 2.50 | 3.33 | 5.83 | 4.24 |
| 6.01 - 6.50 | 1.4% | 94.7% | 43.6% | 2.75 | 3.57 | 6.32 | 4.48 |
| 6.51 - 7.00 | 0.8% | 95.5% | 42.7% | 2.91 | 3.89 | 6.80 | 4.80 |
| 7.01 - 7.50 | 1.0% | 96.5% | 42.1% | 3.08 | 4.22 | 7.30 | 5.13 |
| 7.51 - 8.00 | 0.9% | 97.4% | 43.5% | 3.39 | 4.41 | 7.80 | 5.32 |
| 8.01 - 8.50 | 0.3% | 97.7% | 41.4% | 3.46 | 4.89 | 8.35 | 5.80 |
| 8.51 - 9.00 | 0.3% | 98.0% | 41.8% | 3.72 | 5.17 | 8.89 | 6.08 |
| 9.01 - 9.50 | 0.5% | 98.5% | 40.4% | 3.79 | 5.58 | 9.37 | 6.49 |
| 9.51 - 10.00 | 0.4% | 98.9% | 42.2% | 4.11 | 5.60 | 9.71 | 6.51 |
| 10.01 and UP | 1.1% | 100.0% | 40.0% | 5.55 | 8.30 | 13.85 | 9.21 |

^a Prescriptions in these price ranges dispensed below break-even cost

CUMULATIVE % OF PRESCRIPTIONS BY 50¢ PRICE INTERVALS BY PROVINCES

[illegible]

ONTARIO

25,565 Prescriptions from 117 Pharmacies

| Price Range | % of Total Prescriptions | Cumulative Per Cent | Gross Margin % | Gross Margin \$ | Average Cost Ingredients | Average Price | Break-Even Cost |
|------------------|--------------------------|---------------------|----------------|-----------------|--------------------------|---------------|---------------------|
| \$0.01 - \$ 0.50 | 0.3% | | 63.6% | \$0.28 | \$0.16 | \$0.44 | \$1.07 ^a |
| 0.51 - 1.00 | 6.9% | 7.2% | 63.5% | 0.58 | 0.33 | 0.91 | 1.24 ^a |
| 1.01 - 1.50 | 16.6% | 23.8% | 63.5% | 0.86 | 0.49 | 1.35 | 1.40 ^a |
| 1.51 - 2.00 | 17.5% | 41.3% | 58.9% | 1.07 | 0.75 | 1.82 | 1.66 |
| 2.01 - 2.50 | 12.9% | 54.2% | 55.7% | 1.30 | 1.03 | 2.33 | 1.94 |
| 2.51 - 3.00 | 11.0% | 65.2% | 52.1% | 1.48 | 1.34 | 2.82 | 2.25 |
| 3.01 - 3.50 | 7.5% | 72.7% | 50.7% | 1.72 | 1.66 | 3.38 | 2.57 |
| 3.51 - 4.00 | 6.7% | 79.4% | 48.6% | 1.85 | 1.96 | 3.81 | 2.87 |
| 4.01 - 4.50 | 4.4% | 83.8% | 45.6% | 1.97 | 2.35 | 4.32 | 3.26 |
| 4.51 - 5.00 | 3.3% | 87.1% | 45.3% | 2.18 | 2.63 | 4.81 | 3.54 |
| 5.01 - 5.50 | 2.2% | 89.3% | 44.3% | 2.38 | 2.99 | 5.37 | 3.90 |
| 5.51 - 6.00 | 3.2% | 92.5% | 43.5% | 2.53 | 3.30 | 5.83 | 4.21 |
| 6.01 - 6.50 | 1.8% | 94.3% | 43.9% | 2.78 | 3.55 | 6.33 | 4.46 |
| 6.51 - 7.00 | 0.8% | 95.1% | 43.6% | 2.97 | 3.85 | 6.82 | 4.76 |
| 7.01 - 7.50 | 0.9% | 96.0% | 42.0% | 3.06 | 4.22 | 7.28 | 5.13 |
| 7.51 - 8.00 | 1.1% | 97.1% | 43.9% | 3.42 | 4.38 | 7.80 | 5.29 |
| 8.01 - 8.50 | 0.4% | 97.5% | 40.3% | 3.36 | 4.97 | 8.33 | 5.88 |
| 8.51 - 9.00 | 0.3% | 97.8% | 42.2% | 3.75 | 5.13 | 8.88 | 6.04 |
| 9.01 - 9.50 | 0.5% | 98.3% | 40.4% | 3.79 | 5.58 | 9.37 | 6.49 |
| 9.51 - 10.00 | 0.5% | 98.8% | 42.6% | 4.17 | 5.61 | 9.78 | 6.52 |
| 10.01 and UP | 1.2% | 100.0% | 39.4% | 5.51 | 8.47 | 13.98 | 9.38 |

a Prescriptions in these price ranges dispensed below break-even cost.



I would like to repeat the same question I asked in the March 1958 issue of the Canadian Pharmaceutical Journal, "Is it reasonable and fair that the public should expect the pharmacist to operate his prescription department at a loss making up the loss with by-income obtained from the sale of non-drug items such as soft drinks, ice-cream, tobacco, magazines, toys and novelties?"

Consider the following from the September 1959 issue of the Canadian Pharmaceutical Journal. This is prescription information from the 17th Annual Survey.

| | 143 Pharmacies Prescriptions 10% to 20% of Total Receipts | 104 Pharmacies Prescriptions 20% to 30% of Total Receipts | 74 Pharmacies Prescriptions over 30% of Total Receipts |
|--|--|--|---|
| Sales | \$112,687 | \$91,085 | \$95,853 |
| Prescription Receipts | \$ 19,862 | \$22,711 | \$36,902 |
| Number of Prescriptions Dispensed | 6,842 | 8,389 | 13,620 |
| TOTAL INCOME (Proprietor's or Manager's Salary plus Net Profit before Taxes) | \$ 12,940 | \$12,012 | \$15,443 |

Traditionally, pharmacists have assumed that as the ratio of prescription receipts to total receipts goes up so does total income. If we look at this table showing prescription receipts in the 1958 C.Ph.A. Survey, we find that 143 pharmacies dispensing an average of 6,842 prescriptions for \$19,862, amounting to 17.6% of



1
2 sales. Also we find that 74 others dispensing 13,620
3 prescriptions for \$36,902, that is the last column
4 amounting to 38.5% of sales. We find that the total
5 income of the second group to be \$2,503 more than the
6 first group.

7 On the surface, increased prescription receipts
8 brings higher total revenue. But we seem to have
9 always failed to look in between. What happened to
10 the 104 pharmacies dispensing an average of 8,389
11 prescriptions for \$22,711, amounting to 24.9% of sales?
12 Average total income here was \$928 less than the group
13 of 143 pharmacies receiving only 17.6% of their receipts
14 from the dispensing of prescriptions. For the privi-
15 lege and legal responsibility of dispensing 1,547 more
16 prescriptions they earned \$928 less. To me, the
17 reason seems to be that they dispensed a larger number
18 of low priced prescriptions and hence had larger losses
19 to make up from the sale of non-drug items.

20 Below, I have reorganized these same pharmacies
21 according to sales volume and the average number of
22 prescriptions dispensed per day:
23
24
25
26
27
28
29
30



COMPARISON OF SALES, PRESCRIPTION VOLUME, AND PROPRIETOR'S
INCOME from C.Ph.A. 1958 Survey

| L No. | Sales and | Total | Prescrip- | Number of | Total ** |
|----------|--------------|-------|-----------|---------------|----------|
| 1 of | Prescription | Sales | tion | Prescriptions | Income |
| 2 n Pha- | Size | | Receipts | Dispensed | |
| 3 e rm. | | | | | |
| 4 | | | | | |
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| 18 | | | | | |

| | | | | | |
|----|----|---------------------|-----------|-----------|--------|
| 1 | 20 | Under \$50,000 | | | |
| 2 | 14 | 5-10 Rx daily | \$35,551 | \$ 6,416 | 2,529 |
| | | 10-20 Rx daily | 40,632 | 11,123 | 4,423 |
| 3 | 9 | \$50,000-\$75,000 | | | |
| 4 | 49 | 5-10 Rx daily | \$59,566 | 7,535 | 2,567 |
| 5 | 28 | 10-20 Rx daily | 63,661 | 15,072 | 5,518 |
| | | 20-40 Rx daily | 68,384 | 21,872 | 8,669 |
| 6 | 26 | \$75,000-\$100,000 | | | |
| 7 | 23 | 10-20 Rx daily | \$83,773 | \$ 14,237 | 5,101 |
| 8 | 7 | 20-40 Rx daily | 86,853 | 26,769 | 10,017 |
| | | 40-80 Rx daily | 84,087 | 44,127 | 18,903 |
| 9 | 18 | \$100,000-\$150,000 | | | |
| 10 | 91 | 10-20 Rx daily | \$116,807 | \$ 16,849 | 5,560 |
| 11 | 11 | 20-40 Rx daily | 130,125 | 28,149 | 9,442 |
| | | 40-80 Rx daily | 121,491 | 48,064 | 17,988 |
| 12 | 5 | Over \$150,000 | | | |
| 13 | 11 | 10-20 Rx daily | \$186,227 | \$ 16,587 | 5,813 |
| 14 | 10 | 20-40 Rx daily | 201,450 | 33,689 | 11,752 |
| 15 | 5 | 40-80 Rx daily | 213,351 | 56,235 | 20,205 |
| | | Over 80 Rx daily | 333,385 | 114,196 | 40,174 |

** Total income of pharmacy equals proprietor's salary plus Other Income plus Net Profit. This does not necessarily accrue to one person since 44.1% are Limited Companies and Partnerships.

It is clearly evident from this table that in pharmacies with approximately the same total sales, the total income is highest in the pharmacies that fill the most prescriptions.

But the table clearly reveals that one CANNOT say that in pharmacies with approximately the same total sales total income is more and more as more and



1
2 more prescriptions are filled.

3 For the convenience the lines in the table
4 are numbered.

5 On line four, 49 pharmacies dispensed an
6 average of 15 prescriptions a day and had total income
7 of \$9,516. But on line five, 28 other pharmacies dis-
8 pensing 23 prescriptions a day earned \$116 a year less.
9 If we look at line three, nine pharmacies dispensing
10 only 7 prescriptions a day and then look at line five,
11 28 pharmacies dispensing 23 prescriptions a day, we
12 find that this shift in the number of prescriptions a
13 day or 6,102 more in a year, earned in total income
14 only \$202 more.

15 The situation is equally serious in other sales
16 categories, for example, between \$100,000 and \$150,000.
17 Here on line nine, 18 pharmacies dispensing 15 prescrip-
18 tions a day had a total income of \$15,776 but 91 other
19 pharmacies (line 10) dispensing 25 prescriptions a day
20 had a total income of only \$12,474. In other words,
21 they earned \$3,302 less for the privilege and legal
22 responsibility of dispensing 3,882 prescriptions MORE.
23 Is this not the result of subsidizing low priced
24 prescriptions -- the 46.3% dispensed at a loss -- with
25 the income earned from selling other things?

26 The table on the next page concerns Ontario
27 pharmacies only and is for the year 1959. Here again
28 we find the same story. In the \$75,000 to \$100,000
29 sales category dispensing 20 prescriptions a day
30 (2,375 more in a year) brought \$2,038 LESS total income



than dispensing 14 prescriptions a day. And in the \$100,000 to \$150,000 sales category dispensing 27 prescriptions a day (3,998 more in a year) brought only \$242 more in total income than dispensing 16 prescriptions a day. We hear so much about the "high cost prescriptions" but little if anything about the philanthropy of the pharmacist working hard to earn a profit on the sale of many other things that he might subsidize the "low cost" prescriptions.

Number of Prescriptions
Dispensed Daily

10 to 20

20 to 40

Sales Volume \$50,000-\$75,000

| | | |
|---|----------|----------|
| Number of Pharmacies | 9 | 5 |
| Average Sales | \$62,231 | \$70,218 |
| Gross Margin | 34.0% | 34.0% |
| Total Expenses | 28.7% | 31.2% |
| TOTAL INCOME | \$10,280 | \$11,729 |
| Number of Prescriptions Dispensed Annually | 5,026 | 8,246 |
| Receipts from Prescriptions | \$15,406 | \$26,205 |
| Ratio of Prescription Receipts to Total Receipts | 37.3% | 37.3% |
| Average Prescription Price | \$3.17 | \$3.17 |

Sales Volume \$75,000-\$100,000

| | | |
|---|----------|----------|
| Number of Pharmacies | 6 | 3 |
| Average Sales | \$87,880 | \$84,888 |
| Gross Margin | 33.0% | 34.0% |
| Total Expenses | 26.1% | 31.7% |
| TOTAL INCOME | \$12,821 | \$10,783 |
| Number of Prescriptions Dispensed Annually | 5,139 | 7,514 |
| Receipts from Prescriptions | \$17,611 | \$25,003 |
| Ratio of Prescription Receipts to Total Receipts | 20.0% | 29.4% |
| Average Prescription Price | \$3.42 | \$3.32 |

Sales Volume \$100,000-\$150,000

| | | |
|---|-----------|-----------|
| Number of Pharmacies | 7 | 15 |
| Average Sales | \$120,827 | \$123,549 |
| Gross Margin | 29.8% | 35.0% |
| Total Expenses | 26.0% | 29.9% |
| TOTAL INCOME | \$14,651 | \$14,893 |
| Number of Prescriptions dispensed Annually | 5,937 | 9,925 |
| Receipts from Prescriptions | \$17,752 | \$32,625 |



| | | |
|----------------------------|--------|--------|
| Ratio of Prescriptions | | |
| Receipts to Total Receipts | 14.6% | 26.4% |
| Average Prescription Price | \$2.98 | \$3.28 |

And now may we return to our starting point, the Gross National Product of Canada and the amount Canadian consumers spent on prescriptions in relation to it.

In Table VI, I have related total prescription expenditure to

- a. Gross National Product
- b. Personal Income
- c. Personal Disposable Income

for each year from 1954 through 1959. The increase in prescription expenditure in the five years from 1954 through 1959 was:

- a. 0.1444% of Gross National Product
- b. 0.1023% of Personal Income
- c. 0.1318% of Personal Disposable Income

If we relate prescription expenditures in Constant (1949) Dollars to Gross National Product in Constant Dollars, the increase in the five year period was 0.1204%. Whatever way we take it, the increase in expenditure on prescriptions in five years was one-eighth of one percent of the Personal Disposable Income.

Here I have given the average prescription price for the year 1954 and I might say these are averages of several million prescriptions reported in the Annual Survey of Canadian Pharmaceutical Association and the same price calculated in constant dollars.



| Average Price per Prescription Year | Average Price per Prescription in Constant Dollars |
|--|---|
|--|---|

| | | |
|------|--------|--------|
| 1954 | \$2.28 | \$1.92 |
| 1959 | \$2.98 | \$2.29 |

The increase in the average prescription price in Constant Dollars in five years was 37 cents. The Consumer Price Index in 1954 was 113 and in 1959 - 129.

In this five year period 1954-1959, the average Disposable Income of the Canadian consumer increased \$116.79 in Constant Dollars. In 1959 the Canadian consumer paid 37 cents more of these Constant Dollars for each prescription. The average consumer had 2.5 prescriptions filled in 1959, hence the added expense per person was 93 cents or EIGHT TENTHS OF ONE PERCENT of his additional Constant Dollars.

TABLE VI

| YEAR | TOTAL EXPENDITURE ON PRESCRIPTIONS | GROSS NATIONAL PRODUCT millions of \$ | % of PRESCRIPTION EXPENDITURE TO GNP | PERSONAL INCOME millions of \$ | % of PRESCRIPTION EXPENDITURE TO PERSONAL INCOME | PERSONAL DISPOSABLE INCOME millions of \$ | % of PRESCRIPTION EXPENDITURE TO PERSONAL DISPOSABLE INCOME |
|---------------------------------|--|---|---|---|---|---|--|
| 1954 | \$ 68,664,067 | \$24,871 | 0.2760% | \$18,421 | 0.3727% | \$16,984 | 0.4042% |
| 1955 | 74,372,498 | 27,132 | 0.2741% | 19,738 | 0.3767% | 18,239 | 0.4077% |
| 1956 | 87,404,881 | 30,585 | 0.2857% | 21,885 | 0.3993% | 20,153 | 0.4337% |
| 1957 | 103,230,236 | 31,773 | 0.3248% | 23,024 | 0.4483% | 21,107 | 0.4890% |
| 1958 | 112,438,004 | 32,606 | 0.3448% | 24,440 | 0.4600% | 22,646 | 0.4965% |
| 1959 | 130,871,483 | 34,593 | 0.3783% | 25,940 | 0.5045% | 23,852 | 0.5486% |
| Increase during 5 years 1954-59 | | | | | 0.1023% | | 0.1318% |
| | GROSS NATIONAL PRODUCT IN CONSTANT (1949) DOLLARS millions of \$ | IMPLICIT PRICE INDEX | PRESCRIPTION EXPENDITURES AT MARKET PRICES | PRESCRIPTION EXPENDITURES IN CONSTANT (1949) DOLLARS | % of PRESCRIPTION EXPENDITURES IN CONSTANT DOLLARS TO GNP IN CONSTANT DOLLARS | | |
| 1954 | \$20,186 | 118.5 | \$ 68,664,067 | \$ 57,944,360 | 0.2870% | | |
| 1955 | 21,920 | 118.6 | 74,372,498 | 62,708,682 | 0.2860% | | |
| 1956 | 23,811 | 120.7 | 87,404,881 | 72,414,980 | 0.3041% | | |
| 1957 | 23,749 | 124.9 | 103,230,236 | 82,650,309 | 0.3480% | | |
| 1958 | 23,933 | 128.1 | 112,438,004 | 87,773,617 | 0.3667% | | |
| 1959 | 24,763 | 129.7 | 130,871,483 | 100,903,225 | 0.4074% | | |
| Increase during 5 years 1954-59 | | | | | 0.1204% | | |



1 It has often been said recently that the use
2 of generic names in prescribing would reduce appreciably
3 the cost of prescriptions to consumers. This is conjecture.
4 I pointed out earlier that in my analysis of 42,545
5 prescriptions in 1957 that it cost the pharmacist at
6 least 91¢, exclusive of the cost of the ingredients
7 or any profit to dispense a prescription regardless
8 of the cost of the ingredients, that is, whether the
9 cost of the ingredients be high or low. The use of
10 generic names would not influence in any way these
11 costs of dispensing a prescription. I might say, at
12 this time, that the 1957 figure of 91¢ is now too low.
13 I would say that it is now closer to \$1.10 per
14 prescription. The cost of the average prescription
15 dispensed in Canada in 1959 may be analysed as follows:

| | | |
|----|-----------------------------|---------------|
| 16 | Average Cost of Ingredients | \$1.49 |
| 17 | Pharmacist's Overhead | 1.10 |
| 18 | Pharmacist's profit | <u>.39</u> |
| 19 | Total | <u>\$2.98</u> |

20
21 Of course, the .39¢ is before taxes.

22 The proper question is "How much would the
23 use of generic names reduce the \$1.49 average cost of
24 ingredients?" Whether the cost of the ingredients be
25 \$1.49, \$1.29 or \$1.09, the pharmacist will want to
26 recover his \$1.10 overhead and also have some profit
27 for the legal responsibility of dispensing the pre-
28 scription. A few pennies might be saved for some
29 people now but I think the long-run results would be
30 quite disastrous. I would like to quote Dr. F. P.



1 Rhoades, writing in the Journal of the Michigan State
2 Medical Society:

3 "As a result of the Kefauver hearings there
4 has been a renewed demand for the use of generic names
5 instead of trade names in the prescribing of therapeutic
6 agents. This proposal has been discussed recurrently
7 for over a generation. It is alleged this would greatly
8 lower the cost of drugs to the public. In practice it
9 has proven not to be true as in most cases the pharmacist
10 charges the same price for the generic product as he
11 does for the brand name. Also, the physician under
12 such an arrangement, would be forced to surrender
13 his time honored prerogative of designating the
14 exact medication his medical judgment tells him his
15 patient needs.

16 "If the Pharmacist is authorized to substitute
17 generic products, he must assume the responsibility
18 of deciding which product of those available is the
19 most efficacious and, at the same time, relatively
20 free from side effects. This places an intolerable
21 burden on the pharmacist. Competition may force
22 him to choose the one which gives him the best price
23 advantage.

24 "Although in some incidents the generic name
25 product might be cheaper, there is no assurance it
26 would be identical in every respect. It is well
27 established that the research pharmaceutical houses
28 pursue with almost fanatical zeal, constant quality-
29 control at every stage of preparation of a product that
30 bears their name. It is the brand name that guarantees



1 the quality, potency, safety of vehicles, and freedom
2 from pyrogenic substances. Chemical analysis alone
3 cannot insure this degree of safety. Such quality-
4 control is necessarily very expensive.

5 "If the long range intent is the destruction
6 of independent pharmaceutical research, it would be
7 difficult to formulate a more effective and
8 diabolical scheme. For the substitution of generic
9 products, instead of brand names would inevitably
10 result in the disappearance of free private research.
11 The public would then insist that government fill
12 the void.

13 "The fortunes and continued freedom of action
14 of both the privately practicing physician and the
15 research pharmaceutical houses are bound inextricably
16 together. Any measure that cripples one will
17 invariably affect the other. Any lessening of the
18 pace of pharmaceutical research will result in unnecess-
19 ary deaths. Since the medical profession is dedicated
20 to the saving and prolongation of life, it must
21 vigorously oppose the proposal to prescribe by generic
22 name."

23 The practicability of the use of generic names
24 is much over-rated. In the knowledge of this the
25 Faculty of Pharmacy of the University of Toronto is now
26 studying a large number of consecutive prescriptions
27 in order to ascertain the degree to which the use of
28 generic names could be adapted to the current prescrib-
29 ing habits of physicians. At this stage of the study
30 indications are that the percentage of prescriptions



1 which would lend themselves to the use of generic names
2 is much smaller than public statements by many on the (and
3 question would lead us to believe. When the study
4 is complete this committee may wish to have the
5 results.

6 MR. RICE: Professor Fuller, the obtaining
7 of this data for your statistics, is that obtained
8 by sending questionnaires to the members of the
9 Pharmaceutical Association?

10 PROF. FULLER: A printed questionnaire is
11 sent out early in January of each year to every
12 pharmacy in Canada and the second urge to fill it in
13 is sent out about two or three weeks before the
14 final date for income tax.

15 MR. RICE: And does the return demonstrate
16 a good sample of the Canadian pharmacies, in particular,
17 Ontario pharmacies?

18 PROF. FULLER: It is over ten per cent on
19 all of the pharmacies in Canada. I think any advertis-
20 ing man would say that was an excellent sample. I
21 might say that in the United States starting about
22 1932 the Eli Lilly Company started a similar analysis
23 on a profit basis and I think in only one year out
24 of twenty-eight years have they had more than a five
25 per cent return. The Eli Lilly survey is quoted and
26 known throughout the English speaking world.

27 MR. RICE: I notice in some of your statistics
28 that the number of returns vary greatly. Would this
29 variation have a great effect on the statistics?

30 PROF. FULLER: Yes. I think one thing we



1 should look at and one thing I have always been very
2 careful with in the statistics, I simply take and
3 say that these are the averages of a certain number of
4 replies. Now, if you wish to project that on the
5 nation as a whole, that is fine and is the individual's
6 responsibility. I project it to get the total amount
7 of sales in retail pharmacies in an attempt to get
8 the total amount of money spent on prescriptions in
9 retail pharmacies by that method. The Bureau of
10 Statistics in all of their studies use exactly the
11 same method. In the Department of National Health
12 and Welfare the chief statistician I think he has
13 been moved up recently - Dr. Millard accepts my method
14 of arriving at the amount of the prescription business.

15 MR. RICE: In these returns on these
16 questionnaires did you notice whether one region returned
17 more questionnaires than another region?

18 PROF. FULLER: Oh yes, it will vary.

19 MR. RICE: Well, would that have an effect
20 on your statistics, the fact you got more from one
21 region than another, say, the large cities and perhaps
22 the small country stores.

23 PROF. FULLER: Over 50 per cent, slightly
24 over 50 per cent of the replies are from pharmacies
25 in localities with less than 50,000 population.
26 I would make a guess at about 51.2 per cent. I took
27 the trouble to do exactly this work for another
28 purpose last June and slightly more than half the
29 replies come from pharmacists not in the metropolitan
30 areas.



1 MR. RICE: Would the difference between
2 the limited company type of pharmacy and the individual
3 type of pharmacy make a difference?

4 PROF. FULLER: In what way?

5 MR. RICE: Well, on the returns. Did you
6 get more returns from one type than the other type?

7 PROF. FULLER: I think I stated here the
8 number of returns.

9 MR. RICE: I thought the returns from the
10 limited companies were rather high and I thought it
11 might have a bearing on your statistics.

12 PROF. FULLER: Yes. I have set forth a
13 different year in the survey; the chart space did
14 not permit it this year. In 1958 the individual
15 proprietors represent 56.9 per cent of surveys and
16 9 per cent partnerships and 34.1 per cent were corpor-
17 ations. If you go back to the year previous to that
18 you find 35.3 per cent were corporations. There is
19 a deviation of less than one per cent in the year.

20 MR. RICE: Well, the number of corporations
21 practising pharmacy in Ontario, the ratio of that
22 number of corporations to the number of pharmacists
23 relate to the --

24 PROF. FULLER: I have never attempted to
25 relate them.

26 MR. RICE: Do the corporations include
27 department store pharmacies?

28 PROF. FULLER: No, department stores are very
29 close with their statistics.

30 MR. RICE: And is there any check made on



1 their returns to determine whether they are accurate
2 or not?

3 PROF. FULLER: Many of the returns are from
4 offices of chartered accountants who simply send
5 me a copy of their audited statements and I have to
6 fish the figures out myself.

7 MR. RICE: And there is no check on those
8 not from accountants?

9 PROF. FULLER: No.

10 MR. WREN: For instance, in Metropolitan
11 Toronto have you any idea of the proportion of
12 dispensing which would be done by organizations such
13 as Eatons and Simpsons?

14 PROF. FULLER: I am sorry, I have no idea.

15 MR. WREN: Would you say it would be a
16 large proportion?

17 PROF. FULLER: I would not say it was.

18 As far as the total is concerned, these people, Eatons
19 and Simpsons, would never give us their figures.

20 However, you can get at it by this method; if you
21 went into Eatons and Simpsons and counted the number
22 of diplomas hanging in the dispensaries, as they
23 must hang there by law, you know how many pharmacists
24 each one employs. We can count up the number of
25 pharmacists in all Toronto and strike a relationship.
26 After all, a pharmacist can only do so much work in
27 a day. In this way you can get a little better than
28 a rough idea of the relative amount of dispensing
29 they do.

30 MR. WREN: And in your returns, how many



1 single returns reported? I am thinking now of a
2 small town where there is one store, perhaps six
3 doctors, one drug store and no opposition?

4 PROF. FULLER: Oh, I have done that too.
5 That type of statistic would possibly take about two
6 day's work with a calculating machine to come up with
7 an answer you could put down on one line. If you
8 were going to pay someone to do it it would be expensive.
9 I have done that on occasion for fun. I have noticed
10 over the years that where there is only one pharmacy
11 in a small town the poor chap is just so ignorant of
12 correct business procedure that he is making less
13 money than if he was in a town of 5,000 and had
14 competition. In fact, I was in Winnipeg on the 29th
15 of August speaking to the Manitoba Pharmaceutical
16 Association and one man came up to me and said,
17 "I sent in my survey several years ago, do you remember
18 me?" He told me his name and where he was from.
19 I said, "Yes, I remember you, you wrote me a letter
20 and told me your gross profit was too low and with
21 competition in your town, that is bad." I knew
22 perfectly well there was no competition in that
23 town but his gross margin was about 22 per cent and
24 he was taking home about \$4,000 as his total salary
25 or net profit or income.

26 MR. RICE: Professor, do pharmacists keep
27 a common type of book that keeps their prescriptions
28 different from any other department?

29 PROF. FULLER: Many of them keep a record
30 of the number of prescriptions and the value of



1 the prescriptions separate from their other records.

2 MR. RICE: So that pharmacists could provide
3 you with information with regard to his prescription
4 department with nothing to go through, a whole lot
5 of records to go through to find it.

6 PROF. FULLER: I would say those who keep
7 such records could provide the information. I am
8 a teacher and along with a lot of the members of the
9 faculty of the University of Toronto teach the student
10 that when he goes out into practice he has to do
11 things correctly. Pharmacists have not always kept
12 a record of the prescription sales. If you go back
13 20 years before the discovery of sulfa drugs and
14 antibiotics and antihistamines and that sort of
15 thing, the percentage of prescriptions, the total
16 receipts in the average Canadian pharmacy and also
17 in the United States was not much more than 10 per cent
18 and the pharmacist was as much of a merchant and
19 he never kept track. He did not see any urgency.

20
21
22
23
24
25
26
27 Page 548 follows.
28
29
30



1 MR. RICE: Does the Association or anyone
2 that you know of have a right to examine pharmacists'
3 books?
4

5 PROF. FULLER: I don't think so, not as far
6 as I know. I would like to say it was my belief that
7 the income tax law requires everybody in business to
8 keep a proper set of books -- what they construed as
9 a proper set of records. I don't know.

10 MR. RICE: Can you help the Committee at all
11 as to whether or not there are any weaknesses in these
12 statistics that you have produced or whether they are ---

13 PROF. FULLER: Well, I would like to say
14 there certainly are weaknesses in all statistics.
15 There are weaknesses in all the statistics of the
16 Dominion Bureau of Statistics, but it is physically
17 and financially impossible to eliminate the weaknesses.
18 So these statistics are the best that we have. There
19 are no other in existence, and so we take what we can
20 get and do the best we can with them.

21 These statistics have been kept for years
22 in order to help me tell the student what he has to
23 expect in the operation of his pharmacy; how he is
24 to operate it. For example, the average inventory,
25 the average value of the stock is given. We can,
26 therefore, tell a student approximately how much
27 working capital he will need to operate a pharmacy
28 of a certain size in a certain size community.

29 These are the chief reasons we have gathered
30 these statistics. The fact that it is a help to



1 pharmacists afterwards, having constituted norms by
2 which the pharmacist can compare his operating state-
3 ment with the average of other pharmacists in his
4 group -- I don't like to say this in front of Mr.
5 John Turnbull behind me, but that is a secondary
6 function as far as I am personally concerned -- is
7 the primary function as far as the Canadian Pharmaceuti-
8 cal Association is concerned, although it was not
9 my thought in instituting this nine years ago.

10 MR. RICE: I believe also in your study
11 you did not tabulate the costs per prescription, and
12 the increase over the year of those prescriptions?

13 PROF. FULLER: You mean the cost of individual
14 prescriptions?

15 MR. RICE: Yes.

16 PROF. FULLER: That would be humanly impossible
17 in view of the fact that there are forty million
18 prescriptions dispensed in Canada in a year. This
19 one survey I did in 1957 on forty-two thousand prescrip-
20 tions, the pharmacists did send the individual cost
21 of each one of those forty-two thousand prescriptions.

22 I itemized one after another, along with
23 the price that they got for the prescriptions, and
24 over a period of about four months I picked those
25 out painstakingly, one at a time, and organized them
26 at 50-cent levels, both as far as selling price is
27 concerned and as far as cost is concerned.

28 MR. RICE: What I was directing my reference
29 to, the average cost of a prescription has not been
30 tabulated?



1 PROF. FULLER: When we use the average
2 cost of a prescription here of \$2.98, we mean the
3 average cost to the consumer.

4 MR. RICE: I notice in this other booklet
5 the "Eighteenth Annual Survey" in Ontario you are
6 comparing the average cost of -- RX means prescription?

7 PROF. FULLER: Yes.

8 MR. RICE: You have the 1958 average cost
9 of a prescription as \$2.89, and 1959, it has increased
10 to \$3.21. Also I note over on Page 16 where you have
11 an average cost of prescription for 1950-59 -- I
12 guess that is on the Canadian level -- it is increased
13 from \$1.72 to \$2.98.

14 PROF. FULLER: What year was that?

15 MR. RICE: 1950-59.

16 PROF. FULLER: Yes. \$1.72 is not my figure.
17 It was my predecessor, whoever was in charge at
18 that time. \$1.68 is the average of the pharmacists
19 that replied in that year and sent in prescription
20 data, and that was the first year of my venture, and
21 there were only 149 pharmacies in Canada that replied.

22 MR. RICE: In any event, the average cost
23 of prescriptions is increasing by the year?

24 PROF. FULLER: Oh yes, like everything else,
25 automobiles, houses and so on.

26 MR. RICE: And the increased cost in Ontario,
27 \$2.89 to \$3.21 from 1958 to 1959?

28 PROF. FULLER: That is 32 cents, yes, in
29 this particular group over that two-year period.

30 MR. RICE: Bearing in mind that the cost of



1 a prescription is increasing, as an economist can you
2 help the Committee at all as to why, or what is causing
3 the increase?

4 PROF. FULLER: I tried to point out in my
5 paper here, and I am quite certain in my own mind
6 one of the major reasons for this increase in cost -
7 at Page 15, this does not mean the price of prescriptions
8 has gone up by any large amount. Much of the increase
9 results simply from an increase in use. As I have
10 pointed out, the analogy of the new equipment and
11 electrical appliances and electronic inventions. We
12 have more things now that we can use electricity for.
13 Therefore, our average electric light bill goes up,
14 and it is the same way here. The number of different
15 drugs, and they are marvelous drugs. I don't know
16 much about them. I did teach pharmacology for five
17 years back in the early days before I decided it
18 would be much easier to be an economist than a
19 pharmacologist, and I can say with a certain degree
20 of authority that the drugs that we used 25 years ago
21 just would not do anything in terms of the drugs
22 that have been invented today.

23 In this morning's paper, I think, rheumatic
24 fever in Toronto has been reduced to, was it three
25 in 10,000, by the use of antibiotics, and certainly
26 if we have new uses for new drugs we are far better
27 off even though the cost is going up slightly. It
28 is not going up much higher than our electric light
29 bill.
30



1 MR. RICE: Has the cost of drugs increased
2 differently from the increase in the cost of other
3 products?

4 PROF. FULLER: Oh, no, no, it has not gone
5 up at any higher rate at all. As I have said here
6 at the end that the additional expense per person
7 in five years -- and the statistical work is on
8 the next page showing where I took my figures -
9 the added expense per person during the last five
10 years has been 93 cents per year for 2.5 prescriptions
11 that the average person gets filled. How can we
12 say that 93 cents on prescriptions in a year per
13 person is any tremendous increase?

14 Automobiles, beefsteak, bread and milk and
15 all those things have gone up. How much does 93 cents
16 represent? It represents eight-tenths of one per
17 cent of the additional cost in dollars. In that same
18 five-year period, the average consumer received
19 \$116.79 more money to spend.

20 THE CHAIRMAN: What is it that focussed
21 so much attention on this question of the alleged
22 high cost of drugs?

23 PROF. FULLER: You want my personal opinion?

24 THE CHAIRMAN: I would be glad to hear from
25 you.

26 PROF. FULLER: Let's say the honourable
27 gentleman has now succeeded in becoming elected again
28 to the Senate of a certain august body of another
29 country.

30 MR. WREN: Are you saying, Professor Fuller --



1 THE CHAIRMAN: We didn't have that same
2 opportunity.

3 PROF. FULLER: No.

4 MR. WREN: Professor Fuller, I come from the
5 bush, and I gather from the thread of your brief today
6 if the public are concerned about high profits on
7 drugs, your submission here is to the effect that if
8 there is excessive profits in drugs, the pharmacists
9 are not responsible?

10 PROF. FULLER: Oh, no, they are not responsible
11 at all. They pay the price that the manufacturer
12 and wholesaler sells to them, and it costs them so
13 much to operate their pharmacy and to do that, they
14 must have a profit, because in our society you cannot
15 stay in business -- you have a referee in bankruptcy
16 and the bailiff and the sheriff is on your doorstep
17 the same as I had back 30 years ago. They do not
18 make any exhorbitant amount.

19 MR. WREN: Have you ever wondered whether
20 the wholesale cost is rather high?

21 PROF. FULLER: Well, I have never been
22 employed as an economist by any manufacturing concern
23 as a cost accountant to have any idea of what it
24 does cost to produce drugs in a pharmaceutical plant.
25 It is my own private opinion that the profits are
26 not out of line with profits in other industries.

27 I am not in a position to pass any judgment
28 on the manufacturers at all. My work has been in
29 the retail field. I do feel, however, that the
30 manufacturer has been pilloried a great deal for



1 political purposes, particularly below the boundary.

2 MR. RICE: Has the cost of the ingredients
3 that go into the prescriptions increased in the past
4 years?

5 PROF. FULLER: I would not say the cost
6 of any individual ingredients -- I would say that the
7 average ingredient cost may have gone up because of
8 a change in the nature of the ingredient. The drugs
9 that are prescribed today are just not the same drugs
10 that were prescribed ten or fifteen years ago.

11 In fact, ten years ago certain drugs could
12 not be bought for any price no matter how badly
13 you needed them. If you were a millionaire you could
14 not get them. They did not exist. But any drug
15 that was placed on the market, say, five years ago,
16 or if you made an objective study of the prices,
17 wholesale prices over the last five years, you would
18 find nearly every one of them has come down with
19 an increase in the demand -- therefore their ability
20 to manufacture on a larger scale.

21 MR. RICE: The cost of the drugs to the
22 manufacturer has gone down yet the average cost of
23 prescriptions to the public has gone up.

24 PROF. FULLER: There are a great many factors
25 in there. Perhaps I can put it this way: it happened
26 about two or three years ago at one of the conventions.
27 A man from Nova Scotia said the average prescription
28 price in our area is very low, much lower than the
29 national average because the majority of the people
30 in the community are miners and they are poor.



1 So the physicians make it a practice of writing a
2 prescription for only a three-day's supply. Then
3 they come back and get another prescription, so that
4 they have to pay \$1.50 for a prescription twice a
5 week. That is easier than paying \$3 once a week.
6 When you get all the figures, they average back to
7 \$2.98.

8 MR. RICE: The average cost of a prescrip-
9 tion, we established before it was increasing, is
10 that right?

11 PROF. FULLER: Yes, but not at any higher
12 rate than anything else.

13 MR. RICE: And yet you tell us that the
14 cost of the drugs to the manufacturer is decreasing.
15 They are going down, to the pharmacist.

16 PROF. FULLER: What if a doctor prescribes
17 36 tablets instead of 24? The price of the prescrip-
18 tion has gone up, hasn't it, the average price of
19 the prescription, simply because he gets more on
20 the prescription.

21 THE CHAIRMAN: We can get highly involved in
22 the fallacies of statistical research.

23 PROF. FULLER: Oh yes.

24 THE CHAIRMAN: And I think the most that
25 can be said is, you are presenting various figures
26 here and we accept them as they are presented.
27 If the basis of sampling remains constant from year
28 to year with respect to each of these matters, then
29 the results can be compared from year to year. Would
30



1 that not be correct?

2 PROF. FULLER: Yes. I would say, therefore,
3 that the last two years are the best years, perhaps,
4 where we had 510 in the survey in 1958 and exactly
5 511 in 1959, which is a differential of one. On that
6 basis the average prescription price only went up
7 2 per cent.

8 THE CHAIRMAN: Staying with my point for a
9 minute, the same factors exist today, I would assume,
10 or am I wrong, as existed two or three years ago
11 whether some doctors prescribed 36 tablets and
12 others 3.

13 PROF. FULLER: The same thing, yes.

14 THE CHAIRMAN: So that your average result --

15 PROF. FULLER: No, I would not exactly go
16 along with you 100 per cent, because in medical
17 research and in clinical practice and investigation
18 it may be found that you need various amounts.

19 I can think of one product, for example,
20 Ganthreson, in which the usual directions to the
21 patient would be for a $7\frac{1}{2}$ grain table to be taken
22 every four hours for the first day, and then four a
23 day. The nature of the drug is to eliminate micro-
24 organisms in the gastro-intestinal tract, chiefly the
25 bladder, and if you can keep up the pressure of this
26 drug over a period of time you can kill the bacteria.
27 You have to keep the house in disinfectant for a
28 certain number of days thereafter to see that any of
29 the bacteria don't go into sort of a deep freeze and
30



1 come to life again after the problem has been eliminated.

2 One doctor might say, "You need to take this
3 drug for four days after you have taken a large dose."
4 It might be shown that you get a better result if you
5 take them for six days after.

6 There are tremendous number of factors of
7 that nature that through clinical investigation and
8 research in the last year or so must change the
9 prescribing habits of physicians, and they prescribe
10 more or less of a given drug.

11 THE CHAIRMAN: I actually thought I was
12 trying to help to establish the validity of your
13 figures.

14 PROF. FULLER: I am just trying to establish
15 reasons why the cost may have gone up, some of the
16 reasons it might have gone up.

17 MR. RICE: I also notice ---

18 PROF. FULLER: Could I interrupt for one
19 second? I brought the statistics from the Dominion
20 Bureau of Statistics, from which I got the figures
21 for these other eighteen classes of retail organiza-
22 tions. We used to pay 25 cents for that. That has now
23 gone up in two years' time to 50 cents. It has doubled
24 in price from the government, which is higher than
25 the cost of prescriptions.

26 MR. RICE: I note from your 1959 survey that
27 you have it surveyed out, "Pharmacies with sales
28 volumes below \$50,000 to \$150,000."

29 Just looking at the Ontario column there, it
30



1 would appear that the average price per prescription
2 for those under \$50,000 is \$2.91; for those from
3 \$50,000 to \$75,000 for Ontario it is \$3.07, and for
4 those from \$75,000 to \$100,000 it is \$3.38. For
5 those from \$100,000 to \$150,000, it is \$3.22, and
6 over \$150,000, \$3.24.

7 Is not there an increased trend due to the
8 volume of the average cost of prescriptions?

9 PROF. FULLER: Again there are so many
10 factors that enter into that average cost -- one of
11 the questions at the bottom of the survey was, we
12 asked them to disclose the number of new prescriptions
13 dispensed during the year, and the number of repeated
14 prescriptions dispensed. We got the figure very
15 simply by dividing one into the other.

16 One pharmacy, maybe in a small village where
17 he is not aware of the present prescription procedures,
18 may be dispensing 46.3 per cent of his prescriptions
19 at a loss, and we have them where the average prescrip-
20 tion price for an individual pharmacy is as low as
21 \$1.75 for thousands of prescriptions in a year. We
22 have others where the average prescription price might
23 be \$3.50 in another locality.

24 We cannot say that the medicinals that
25 enter into the prescription in both cases are anywhere
26 near the same, and we get our average by putting those
27 two together and dividing them. They are arithmetical
28 means, and that is all they are.

29 MR. RICE: There is no significance, I take it,
30



1 from your answer as to the increase in average price
2 per prescription of the size of the business done by
3 the store.

4 PROF. FULLER: I would not like to say that
5 there was any significant trend in prescription
6 prices as a result of the increase in total volume of
7 the store.

8 I mean, I think we have to take the pres-
9 cription volume by itself. On page 18 I abstracted
10 the columns that you were referring to. Instead of
11 having to look at each one of the four charts in order
12 to get this comparison, I have done that on page 18.
13 There you will find the differentiation of one group,
14 \$3.09, \$3.30, \$3.20, \$3.26, and the number of
15 prescriptions, 4,878 at one end; 18,000, 13,000, and
16 so on at the other end. So I do not think you can
17 get any trend out of that.

18 MR. RICE: Professor Fuller, in your survey
19 do you recall whether or not the large chain stores
20 made a return, such as Tamblyn's and Liggett's?

21 PROF. FULLER: No. Chain stores such as
22 Tamblyn's and Liggett's are not in this survey in any
23 way, shape or form.

24 MR. SUTTON: I was going to point out we
25 have heard from an official of the Workmen's
26 Compensation Board about the cost of drugs twelve
27 years ago on claims. He also pointed out they used
28 very few drugs, and the cost was 70 cents per claim
29 twelve years ago. Today has gone up to \$2.80.
30



1 Your survey has not shown any increase amounting to
2 four times.

3 PROF. FULLER: No, it is not that high at all.

4 There I would like to speak as an economist
5 and as a statistician, not trying to prove anything
6 one way or another except to get at the hard facts,
7 the core of the situation.

8 When the average cost to the Workmen's
9 Compensation Board was 70 cents, I would want to
10 analyze very closely the nature of the ingredients
11 in every prescription at that time, with the nature
12 of the ingredients that are being used today. It is
13 only by that method that we can come to any valid
14 conclusions as to what is going on, to take a pres-
15 cription for tinctures and fluid extracts, and such
16 things that were used years ago, and try to correlate
17 them with the antibiotics that are used today, -- and
18 you have to realize that oftentimes one or two shots
19 of an antibiotics keeps a patient out of hospital
20 for a week or so and puts him back to work in three
21 or four days, when he might have been away for six
22 weeks.

23 We fail to realize the saving of other
24 expenses when the cost of a prescription comes up.

25 MR. TROTTER: I would like to ask Professor
26 Fuller if he has any idea what percentage of the
27 retail drug business would be done by the chain
28 stores such as Tamblyn's.

29 PROF. FULLER: I had that in my rough draft.
30



1 It could be obtained from the bulletin on retail trade
2 of the Dominion Bureau of Statistics as of December
3 of any year. At the present time, I do not think I
4 am out any more than a second decimal place, in
5 Ontario the chain stores do about 13.24 per cent of
6 the total business, and the independents do the
7 balance which would be 86-point-something per cent.

8 The chain stores do perhaps about 1 per cent
9 more of the total retail trade in pharmacies in
10 Ontario than the average overall in Canada as a whole.

11 MR. TROTTER: Would Eaton's and Simpson's
12 be included in the chain stores?

13 PROF. FULLER: I could not answer that
14 because I do not know whether the DBS includes Eaton's
15 as a chain or as a department store.

16 MR. TROTTER: Would you have any idea, sir,
17 if the chain stores operate more cheaply than the
18 individual druggists?

19 PROF. FULLER: That is a question that has
20 been kicked around the field of marketing for 20 or 25
21 years.

22 Tens of thousands of dollars have been
23 spent both in Canada and largely in the United States,
24 and the answers are fairly well negative, for this
25 reason, that a chain store system cannot be compared
26 adequately with a system by which the independent
27 retailer buys from a wholesaler, and the wholesaler
28 from the manufacturer. The chain store system is
29 an entirely different system.
30



1 A chain store, Tamblyn's, for example, are
2 in wholesale, and they perform a wholesale function.

3 The question asked is, can the chain store
4 perform some wholesale function more cheaply than
5 the retailer buying wholesale, to the extent that they
6 can pass on any possible savings to the public through
7 the economy of lower prices.

8 I will put the question this way: the
9 leading chain store in Canada has approximately 150
10 pharmacists across Canada, the majority of which are
11 in Ontario and a large percentage of them are in
12 Toronto. That is, 150 stores.

13 In Ontario we have Drug Trading which is a
14 wholly-owned co-operative. No one but a pharmacist in
15 Ontario can own a single share of stock in drug
16 trading. They have nearly 1,700 members and they
17 will have their annual meeting tomorrow night. Can
18 an organization of 1,700 members who patronize them
19 with weekly orders buy better and cheaper for 1,700
20 than another organization can for only 150? I will
21 let you answer.

22 MR. RICE: Would the fact that these large
23 chain stores and department stores are not included
24 in the statistics have some bearing on those
25 statistics?

26 PROF. FULLER: You can compare it this way:
27 I do not think chain stores do any larger percentage
28 of prescription business than non-chain stores. In
29 fact, I think they do less percentage-wise. Possibly
30



1 their percentage relationship of prescription sales
2 to total sales would not run more than 15 or 18 per
3 cent. You can get right at it with a calculating
4 machine if you take the total volume of retail
5 sales in Ontario. I have given it here as 171 and
6 13.24, approximately, checking first with the
7 Dominion Bureau of Statistics booklets on retail trade.
8 You can make sure of the exact figure by checking with
9 them, and you multiply the two, and you have got the
10 total amount of chain store business in Ontario.
11 Then you take roughly 15 per cent of that as being
12 the prescription business.
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29 --- (Page 572 follows.)
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2 PROF. FULLER: Then you have the factual
3 comparison; the amount of prescription dollars that
4 flow into chain stores versus independent. Not hard
5 to do.

6 MR. RICE: Professor, I note also that
7 the average price of the new prescriptions and the
8 average price of a repeated prescription differs.
9 Could you explain to the Committee why the difference
10 in price between a new prescription and a repeat of
11 that prescription?

12 PROF. FULLER: For the simple reason, that
13 if we had a chart in here of the average total
14 operating expenses of pharmacists, either in Ontario
15 or all of Canada for the last nine or ten years, we
16 would find that his average operating expenses were
17 going up.

18 Therefore, the average prescription price
19 has a tendency to go up in order that the pharmacists
20 might be able to meet the ever increasing expenses.

21 If you have a prescription filled in 1959,
22 say a year ago today, it was priced much as things
23 stood at that time, and prices have gone up and
24 operating expenses have gone up.

25 In 1960 you take your prescription number
26 and go back and get that prescription, the pharmacists
27 will be - he won't want to increase the price even
28 though he feels he should. As long as you don't have
29 it filled too often, he will charge you the same price
30



1
2 as he did a year ago, or two years ago or even five
3 years ago but the increasing cost in this year, if you
4 have a new prescription, he would charge you a little
5 more.

6 As I say, in 1957 the operating expenses
7 of the pharmacists I calculated to be conservatively
8 91 cents for dispensing a prescription. I think it
9 is still very very conservative to say the cost is
10 \$1.10.

11 THE CHAIRMAN: Mr. Rice, would this not
12 be a good place for us to adjourn for lunch? By a
13 prior arrangement, Dr. Ian MacDonald is coming at
14 3 o'clock, and I mention that because that will let
15 you out not later than 3, at least for today, if that
16 is convenient, Professor Fuller.

17 PROF. FULLER: It means I must cancel
18 a class if you desire.

19 THE CHAIRMAN: When would it be convenient
20 for you to come back?

21 PROF. FULLER: I would rather get it over
22 with today. I would think it would be much better
23 for all concerned.

24 THE CHAIRMAN: I think that I can see a
25 line of questioning that is bound to come up with
26 respect to your evidence that I would think would not
27 be finished in an hour, or two hours.

28 PROF. FULLER: Would you like me back at
29 2 o'clock today?
30



1
2 THE CHAIRMAN: No, we want to meet your
3 convenience.

4 PROF. FULLER: I would rather come back
5 at 2 o'clock today if it can be completed today.

6 THE CHAIRMAN: I don't think there is a
7 chance of that Professor Fuller.

8 PROF. FULLER: Tomorrow?

9 THE CHAIRMAN: Tomorrow would be agreeable
10 to us.

11 PROF. FULLER: What time?

12 THE CHAIRMAN: 10 o'clock.

13 PROF. FULLER: 10 o'clock, all right.

14 THE CHAIRMAN: Fine. Then that will leave
15 you free this afternoon. That means we will not
16 reconvene until five minutes to three this afternoon.

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18 --- Luncheon recess.
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2 --- On resuming at 3.00 p.m.

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4 THE CHAIRMAN: This afternoon Doctor Ian
5 Macdonald has graciously come down to appear before
6 the Committee. Doctor Macdonald will you come down?

7
8 --- DR. IAN MACDONALD (Comes forward)

9 THE CHAIRMAN: Doctor Macdonald is
10 Director of Post Graduate Studies in the School of
11 Medicine at the University of Toronto and Senior
12 Consultant at Sunnybrook Hospital, among other
13 accomplishments.

14 DR. MACDONALD: Now Mr. Chairman, members
15 of the Committee, I assume that I can be most use to
16 you if questions were directed to me, but I might say
17 something about the questions which were directed to
18 myself, as far as the background of this Committee is
19 concerned. Would that be in order?

20 THE CHAIRMAN: That is agreeable.

21 DR. MACDONALD: I understand, sir, that
22 you are interested mainly, as far as I am concerned,
23 in methods that we use in teaching graduate students,
24 and post graduates and I must amplify that by saying,
25 and perhaps it is redundant, that medicine, like law,
26 is a lifetime study, and that when people graduate
27 from medical school they have basic education but they
28 are on their professional responsibilities and we hope
29 a firm foundation upon which they can build the future
30



1
2 experience and learn more rapidly than otherwise
3 would be the case.

4 It is also perhaps redundant to say that
5 science has increased so rapidly in its application
6 and basic knowledge in the last 35, 40 years, that it
7 is very difficult for any one person's memory to cope
8 with the number of facts in a profession that he needs
9 to use, and consequently, there are great strains on
10 the memories of doctors, as well as other professions
11 and they have to learn to take in what is likely to
12 be useful in their work, and make a mental note of
13 the other material and know where to get it, if needed
14 so all of us in medicine, at any rate, are deluged with
15 an amount of information that has come out each year
16 from the laboratories, medical schools, scientific
17 labs, and labs of drug firms, and so on, and we have
18 to take as much of this information as we can,
19 approximately, and we certainly are responsible for
20 taking that which might be useful to us in our work
21 so that the post graduate education of a doctor is
22 not all formal.

23 Some of it is done through regular courses
24 put on by different medical schools, medical societies.
25 Some of it is through hospital meetings and ward rounds.
26 Some of it is by reading different journals, and by
27 reading some of the very voluminous literature that is
28 sent to most doctors by different drug houses;
29 literature, I might say, of varying quality from the
30



1
2 highest and first rate, to perhaps some that is very
3 questionable, but nevertheless it all has its use
4 and application.

5 Now I did bring with me, and it may not be
6 useful to you but gives some idea as to what we are
7 doing in the post graduate division in a formal way,
8 and these are - most of them are brochures of last
9 year's courses, about this number (indicating),
10 directed to different branches of the profession, and
11 while most of these are broad in their applications,
12 a few of them are specific in terms of drug treatment,
13 and I have here one programme that might be of interest
14 to you, and that is the medical alumni course which
15 is scheduled for October 12th, 13th and 14th of this
16 year in which the main theme is current therapy, or
17 treatment.

18 I mention this because it illustrates the
19 fact that doctors are very conscious of the need of
20 having formal refresher courses, and by having courses
21 which bring to them new knowledge from people who may
22 have had an opportunity of being exposed to the -
23 having the opportunity of using medical treatments in
24 a sufficient number of cases to draw reasonable
25 conclusions about the usefulness or otherwise of the
26 treatment.

27 At hospital rounds, as the Committee must
28 know, the organization of all hospitals nowadays
29 requires that staff meetings be held. While these
30 meetings vary in their excellence, of course, depending



1
2 partly upon the local situation and individuals
3 concerned, most of them - in fact I would say that
4 all of them serve a very useful purpose of exchanging
5 experience and the very nature of our training is
6 such that we are very keen to find out things that
7 will help us to do more for our patients.

8 We are very conscious that we have our
9 limitations and actually apart entirely from the
10 difficulty of diagnosis, there are a good many diseases
11 in which we feel very handicapped because of the lack
12 of really secure treatment measures. This is a state
13 of mind. Everybody in the profession is keen to do
14 better so if something new comes along, particularly
15 when a very dramatic claim is made for its usefulness,
16 doctors are very keen, first, to find out how the drug
17 or preparation should be used, and then to try it.
18 This is presuming that it is a safe drug and it has
19 been properly tested to see how it works, and that,
20 I think, accounts for one of the reasons why there is
21 a tendency for doctors, as well as their patients, to
22 be interested in the new.

23 As a matter of fact, this is such a striking
24 thing, and we are no different from the communities
25 in which we live. No doctor can separate himself
26 from the community in which he labours. He thinks
27 very much the same as the people around him. People
28 are very much fascinated by the new, particularly if
29 it comes out under a cloud, or not a cloud, bright
30 sunshine, very striking claim for its usefulness so



1 there is a tendency for more and more drugs to be
2 used, and of course as you all know, there are a
3 terrific number of these drugs still coming out;
4 scads of them coming out.

5 Some of them may prove to be -- we know
6 will prove to be useless; some of them we suspect
7 will prove to be harmful but we know that every now
8 and again one comes out and achieves the purposes
9 we are looking for, and that is to do better for
10 patients.

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20 Page 582 follows.
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Now, there is one phase of graduate education which is very effective in terms of using drugs in which you people are interested today. This is what I call graduate training. These people work full time in hospitals as interns, residents or fellows and thus have the opportunity of having direct responsibility for patients under supervision. As they are under supervision and as most of them are young, fairly intelligent and well trained and have a good deal of enterprise they tend to try different drugs in different conditions. Under supervision, which they are in any good hospital, this can be very useful to their education. This does not constitute any harm to the patients, as a matter of fact, it is a good thing for the patients. Anyone who does bedside teaching seizes the opportunity to talk about drugs. I can think of one sort of tiresome habit I have of talking about two drugs. This is a situation in which I am sure one drug is better than the other. I have looked into costs and I know that the better drug is 30 times less expensive than the second drug which is a pretty good drug. Unfortunately, it is very hard to convince everybody that this difference in price is really reflected in the difference in usefulness. Our modern civilization is such that if an automobile costs \$5,000 people assume it is better than one that costs \$2,000. If a drug costs \$5.00 for 25 tablets it is human nature to assume that the drug that costs 50 cents for the same number of tablets is not quite as good; as a matter of fact,



1 some people would think it is no good at all. In
2 medicine we know that there are cheaper drugs which
3 are better than some of our expensive ones. That
4 type of teaching is going on all the time in hospitals.

5 I must emphasize that in medicine we cannot
6 insist that a doctor use a drug that in his conscience
7 he believes is not the best one. Cost cannot be
8 effective. If I believe that drug A is a drug that
9 my patient really needs, while I may be very conscious
10 of the cost and the burden it puts on that patient
11 or his family, I am really honour bound to prescribe
12 that drug. I think, and we teach, that it is our
13 responsibility to look at drugs critically and decide
14 what is the best drug for our patient. If there are
15 four drugs that will fulfill the criterion best
16 then we decide which is the less expensive. It is not
17 much use -- well it may be of some little use but
18 not much -- to cure a patient and send him out of
19 the hospital seriously distressed and in a position
20 where he cannot buy good red meat and a week's holiday
21 to finish his convalescence.

22 These are all general observations and I
23 could go on for hours or perhaps it may be better
24 if someone asked me questions.

25 MR. RICE: Do you belong to any of the medical
26 associations?

27 MR. MACDONALD: Yes.

28 MR. RICE: What associations do you belong
29 to?

30 MR. MACDONALD: Well, I belong to the Canadian



1 and Ontario Medical Associations, the Academy of
2 Medicine. I belong to some special societies such as
3 the Royal College of Physicians and Surgeons of Canada
4 and the American College of Physicians.

5 MR. RICE: Do those associations have any
6 program to enlighten medical men of new drugs?

7 DR. MACDONALD: Well, not too much.
8 Let me modify that a bit; in the meetings that are
9 put on by the different associations -- take the
10 Academy of Medicine in Toronto which puts on a very
11 active program each year of lectures and meetings
12 that in itself covers some of the needs that I
13 think you are interested in. It is no use, in fact
14 it is silly to talk about the treatment if one has
15 not considered diagnosis and any medical board follows
16 the regular pattern in talking about diagnosis of
17 the condition at issue and it employs a treatment.
18 I could say more but if I do I would have to explain
19 it too much. In most medical circles, except in a
20 very informal atmosphere of a hospital meeting, costs
21 are not mentioned. The doctor just says what they
22 think of drug X. They might say they have treated
23 65 patients with this preparation but they do not
24 mention costs at all. He just implies it is the best
25 drug as far as he is concerned and, therefore, it
26 is a responsibility of the people concerned to find
27 out about them.

28 MR. RICE: Would you tell the Committee
29 whether detail men from drug manufacturers have any
30 influence on the medical profession with regard to new



1 drugs?

2 DR. MACDONALD: I am sure they have a tremen-
3 dous influence and I use the word in the broad sense.
4 I happen to be chairman of the Pharmaceutical Committee
5 of Veterans Affairs which is a committee made up of
6 people across Canada. Now and again I enquire what
7 is going on and now and again I get a request from
8 Ottawa as to whether or not this new drug should be
9 stocked. I talk to the pharmacist about it and he
10 says so and so and such and such a firm is making a
11 trip across Canada and I predict we will have a request
12 from Vancouver within ten days or two weeks and usually
13 we do. This is in the case of a very good detail
14 man who is perhaps pushing a very good product --
15 it might or might not be good but probably it is.
16 We have to decide in a big service where the cost of
17 drugs is considerably less than to the public because
18 we get them by tender, whether or not to stock that
19 drug. We have a pretty good policy about that.

20 MR. RICE: Does the Association or anyone
21 have any facilities for testing these new drugs that
22 come on the market other than just trying them out
23 in the hospital?

24 DR. MACDONALD: Well, before the drug comes
25 on the market every reputable maker tests it very
26 carefully first from the pharmacological point of
27 view and if it fulfills all their criteria of safety
28 and usefulness then there are clinical trials in
29 an area where there are enough patients for a reasonable
30 time to enable them to draw conclusions. I think



1 believe that you have to satisfy the requirements
2 of the Health and Welfare Drugs Division. It is not
3 the medical schools or medical associations responsibil-
4 ity to test drugs.

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1 MR. RICE: Well, these clinical trials, are
2 they carried on under the auspices of the manufacturer,
3 or is there someone else?

4 DR. MACDONALD: Usually the main manufacturers
5 do not have facilities for clinical trials, but what
6 they do, they arrange with some hospital or medical
7 school or clinic that has not only the clinical
8 material available, but the professional staff who
9 have enough experience in a clinical type of line to
10 try the drug out and see what they think.

11 Sometimes you might say it is indirectly
12 under the auspices of the drug people because they
13 will, not infrequently, provide a fellowship for
14 somebody to do the labour work on the thing. That
15 is the day-to-day work under supervision.

16 MR. RICE: Do some drug companies have
17 medical doctors attached to their company as consultants
18 for this purpose?

19 DR. MACDONALD: Well, the big ones do.
20 The big ones have very large and capable staffs.

21 MR. RICE: Do medical men see samples of
22 new drugs coming on the market?

23 DR. MACDONALD: They are deluged with
24 samples, sir.

25 MR. RICE: And do those samples have an
26 influence on a medical man to try a new drug?

27 DR. MACDONALD: Yes, I am sure they do.
28 I am sure they do. The number of new drugs coming
29 out in any one year, it is not astronomical,
30



1 but it is larger than human memory can take in unless
2 you are dealing with nothing but drugs. How from a
3 psychological point of view, how do you get -- I think
4 if I were a manufacturer I would like the profession
5 to use my drugs-- but how can you get them to use it?
6 First, you must convince them it is a good thing,
7 and having convinced them of that, you must make sure
8 they remember it is a good thing.

9
10 If you send along a doctor four or five vials
11 of penicillin tablets with your own name on them, and
12 it is a good product, and you are convinced it is good,
13 he tries it out three or four times and his patient
14 comes along or their infections get better, he
15 remembers that name, and he gets another case of
16 pneumonia -- this is penicillin -- if I know that
17 penicillin, special brand of Rowntree Penicillin
18 worked very well, therefore I might prescribe it.

19 MR. RICE: Do your medical men very often
20 throw out these samples or do they use them, in your
21 experience?

22 DR. MACDONALD: I would guess that in the
23 cities a great proportion of them are thrown out.
24 I get a number of them, and I take some of them myself.
25 Sea-sick pills, for example, very glad to get them
26 because I know they are good.

27 MR. RICE: To what extent have publications
28 that are available to the public an influence on a
29 doctor trying a new drug? That is, a patient reads
30 about some wonder drug in the newspaper and comes in



1 and sees the doctor and asks them all about it.

2 THE CHAIRMAN: Or in the Reader's Digest?

3 MR. RICE: Yes.

4 DR. MACDONALD: I was at a medical meeting
5 last year in the States, and a new drug was being
6 discussed at the table. It turned out this drug
7 had not been really reported in the Medical Journals
8 at all. It appeared in a prominent American publication
9 that had a rather nasty little picture of Mr.
10 Khrushchev in it last week on its cover, and some
11 people rose to say the first medical literature they
12 read is a copy of a small journal, that the Chairman
13 referred to, and a copy of Time.

14 You have to keep ahead of your patients.
15 A little knowledge is a dangerous thing, and the
16 patient reads about a drug in one of these publications,
17 and the doctor has never heard of it -- he is never
18 foolish enough to admit it -- and he is sort of almost
19 forced to prescribe it.

20 MR. RICE: Is that actually occurring you
21 think in Ontario today?

22 DR. MACDONALD: I cannot tell you that, but
23 I think I might give you an educated guess and say yes.
24 Human nature being what it is, and I see patients in
25 consultation, and this happened to me about two months
26 ago, and the family concerned were very keen that I
27 recommend a certain type of treatment. Well, for-
28 tunately, I knew that the thing was absolutely silly,
29 and I knew it was not going to do any harm. My
30



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2 responsibility was to the patient and not to the
3 family, and I was able to resist that, but it is not
4 always easy to say to people "Well now, that is silly",
5 because as you know doctors are always -- not always
6 -- but very often suspected of being ultra conservative,
7 and they may have some ulterior motive for not using
8 a drug and so on and so forth.

9 MR. RICE: You mentioned before, Doctor,
10 you had consulted pharmacists I believe. Do pharmacists
11 have an influence on doctors as to what drugs, new
12 drugs they should try?

13 DR. MACDONALD: No, I don't think the
14 ones they should try. A pharmacist, a good pharmacist
15 is a very great help to us because he knows the
16 physical properties of the drugs, and he knows, for
17 instance, whether certain tablets tend to disintegrate
18 more easily than others. When you are prescribing
19 a drug that is going to be used over three or four
20 months, and you are giving it to someone that is
21 travelling, you don't want to give a drug that is
22 going to fall to pieces under those circumstances.
23 If I am suspicious of the thing, I say: "How do these
24 things stand up? What are they like on the shelves,"
25 and so on, and we ask the pharmacists about liquid
26 preparations, whether they tend to lose their colour
27 or whether they tend to form sediments, and we often
28 ask about different makers of drugs.

29 Every now and again we find we get a contract
30



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2 filled, and I get letters from different hospitals
3 saying they are little skeptical about it from the
4 point of view of its physical appearance. It develops
5 a cloud, and they say "Is this good or bad?". I
6 talk to the pharmacists under those circumstances
7 because he has knowledge that I haven't got. If you
8 want to get an expert opinion on the physical
9 properties of drugs, I call the pharmacist.

10 MR. RICE: Is there any movement afoot
11 to order drugs by generic names rather than trade names?

12 DR. MACDONALD: There is a very strong
13 movement for, and there is a very strong movement
14 against, as you probably know. You asked a question
15 earlier on about drugs, do doctors use drugs and why,
16 in the samples. A catch name is easier to remember.
17 The generic name is sometimes difficult to remember.
18 That is one factor. The next factor is that there is
19 on this continent -- this, perhaps, Mr. Chairman,
20 is outside my province -- but there is on this
21 continent a strong movement to suggest that brand names
22 are the things to buy not only in drugs but refrigerators
23 and radios and this, that and the other thing, and we
24 know as far as the generic names of drugs is concerned,
25 it is the preferable thing.

26 Aspirin is a case in point. Before the
27 patent ran out on aspirins, if you prescribed aspirin
28 you got aspirin in which the patent was on them.
29 I used to order acetylsalicylic acid which was about
30



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2 50 per cent less expensive. We know chemically it
3 is the same thing. It is relatively easy to manu-
4 facture, and you are not going to get into difficulties.

5 The generic names, some of the antibiotics
6 -- in Veterans' Affairs we have drawn up a
7 pharmacop~~ia~~ using generic names. You will find
8 questions are raised: "Are we wise in ordering by
9 generic name? How do you know the maker has the
10 proper checks and balances?" Well, I go on the
11 principle, Health and Welfare, Drugs Division, are
12 responsible for checking of manufacturers and goods
13 if they are from out of the country coming in.
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15 (Page 594 follows)
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2 Therefore, anything that you buy under a
3 generic name from a Canadian firm should be - you
4 should get what you order if it is bought under the
5 generic name.

6 MR. RICE: Speaking for yourself as a
7 person well qualified, what is your personal preference?

8 DR. MACDONALD: My personal preference is
9 to order by generic name.

10 MR. RICE: Is there any power or any
11 right left to the druggist to make a selection when
12 you order by generic name?

13 DR. MACDONALD: For instance, if we order
14 something by generic name, take acetylsalicylic acid,
15 the druggist may fill that from any one of twenty
16 different makers. Whether he may be a good buyer,
17 and the patient get it very cheaply, or whether he
18 may be a poor buyer in small quantities and it may cost
19 more, it still won't cost as much as by a brand name.

20 MR. WHITE: Is a druggist obliged to
21 supply the cheapest?

22 DR. MACDONALD: I cannot answer that.
23 I do not believe he is obliged to supply the cheapest
24 at all; as a matter of fact, if he orders by generic
25 name, he can, yes. I am not qualified to say this.
26 I would think he could use the most expensive trade
27 name, although I would think he would be morally
28 obligated to supply the cheapest drug, if not the
29 cheapest, at least - "cheapest" has an emotional
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2 ring to it.

3 MR. WHITE: I mean in your own practice?

4 DR. MACDONALD: I am not in practice,
5 but I think they should supply drugs chiefly under
6 generic names.

7 There are some drugs that I order and I will
8 specify the maker. That is because on the basis of
9 experience I have found that this particular maker
10 makes something that is particularly reliable. I
11 use to do that with digitalis some years ago when I
12 was ordering. I knew of two firms that had very
13 careful checks on digitalis preparations, as most of
14 them do now, but there is no use prescribing a potent
15 drug to do a particular job and find you are getting
16 something that may or may not be what you have ordered.

17 THE CHAIRMAN: That is probably reflected
18 in the fact, Dr. Macdonald, and my information is,
19 that there are some pills or drugs that in a single
20 pill would contain 1/3,000 of a gram of the drug
21 itself, so that an error making it 2/3,000 would be
22 double the dose?

23 DR. MACDONALD: That is right. That is one
24 of the things. But it may be that the substance
25 producing the biological action is not present in
26 sufficient quantities, or it even may be in greater
27 quantities. Digitalis being a case in point, you
28 want to get the full effect, but you do not want to get
29 the poison.
30



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2 MR. RICE: On the question of full effect,
3 Doctor Macdonald, are there certain side effects from
4 new drugs that you have to be careful of?

5 DR. MACDONALD: There may be side effects
6 from any drugs. Five grains of aspirin may kill some
7 people. I know of a case where a child was killed
8 using aspirin. I use the word "aspirin", let us say
9 acetylsalicylic acid.

10 Hypersensitivity is of particular significance
11 in some of these new drugs with side effects that may
12 or may not be acceptable. For instance, some new
13 drugs may be prescribed and we know they will have
14 side effects, but they are small compared to the good
15 effects or benefits, and the cure is not worse than
16 the disease. But there are other drugs where the
17 cure is worse than the disease.

18 MR. RICE: In your opinion, does the
19 Food and Drug Act provide ample protection as to the
20 purity of the drugs in Ontario today?

21 DR. MACDONALD: I cannot answer that, sir,
22 because I am not completely familiar with the Food
23 and Drug Act, but in any contacts I have had with the
24 Department in Ottawa, and talking with the people who
25 are responsible for this, I would think that it does
26 guarantee that. That is not an opinion founded on
27 solid fact, it is my own opinion.

28 MR. RICE: Yes, Do you know of any difficulties
29 in Ontario with regard to counterfeit drugs on our
30



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2 market either by generic name or by brand names?

3 DR. MACDONALD: Could I ask a question,
4 Mr. Chairman?

5 THE CHAIRMAN: Yes.

6 DR. MACDONALD: What do you mean by
7 "counterfeit drugs"?

8 MR. RICE: The term was used yesterday
9 by the Retail Pharmacists' Association where some names
10 of Canadian companies were used in connection with
11 counterfeit drugs in the United States. I understood
12 what they meant was they were drugs intended to appear
13 and look like a certain brand name drug when, as a
14 matter of fact, they were not.

15 DR. MACDONALD: I am sorry, I cannot answer
16 that. I thought you meant, perhaps, drugs were being
17 sold under generic names which were infringing perhaps
18 on Canadian patents. I would not call those counter-
19 feit drugs, I would just call those drugs that are
20 against our patent laws, which is not a problem for us.

21 If the drug is against the patent, it still
22 does the job, and it is not up to us to do anything
23 about it. It is a legal problem, not a medical
24 problem.

25 MR. RICE: I was just wondering about your
26 experience in your capacity as a doctor

27 DR. MACDONALD: I am not practising now.

28 MR. RICE: Have you heard if there is any
29 problem in Ontario?
30



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2 DR. MACDONALD: No, but I know we have
3 had a good many discussions about some drugs that
4 have been made abroad and marketed in Ontario under
5 generic names, and so far as I know the only argument
6 has been whether this is a good thing or not from the
7 point of view of law and morals, but not whether this
8 is a good thing in terms of the patients. I think
9 it does not make any difference to the patient as
10 long as it is a pure product.

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1 MR. RICE: Doctor could you help the Committee
2 at all as to whether, in your opinion being closely
3 connected with drugs, whether the cost of drugs in
4 Ontario for treatment purposes is rising?

5 DR. MACDONALD: I think the cost of drugs
6 is rising, like most other things.

7 MR. RICE: Do you think that it is rising
8 more than other things? I can't

9 DR. MACDONALD: I cannot answer that, really.
10 The cost of drugs is very variable. A prescription
11 filled in one pharmacy may cost the patient less
12 than another prescription, the same prescription filled
13 in another pharmacy.

14 That is a problem of retailing; got nothing
15 to do with medicine.

16 MR. RICE: Have you any recommendations
17 that you can make to the Committee with regard to the
18 handling of drugs in Ontario?

19 DR. MACDONALD: I don't know sir if I am
20 qualified to do that. This is to me an awfully
21 complicated problem and it's involved because commerce
22 and human beings happen to be mixed up, and I was
23 thinking as I was driving down about insulin. The
24 Committee undoubtedly knows that at the time of
25 Frederick Banting's discovery of insulin at the Univer-
26 sity of Toronto, he, I think, very wisely patented
27 it, patented the discovery and then they sublet, what-
28 ever you call it sublet the rights to manufacture
29 insulin but they kept control of the price and I
30 think that ensured that insulin was marketed at a price



1 in relation to its manufacturing cost.

2 I think the same applies to liver extracts,
3 both of which are terrifically useful drugs, biological
4 preparations, so a person with diabetés, or a person
5 with pernicious anemia gets the sustenance that sustains
6 life at a reasonable price; that is, reasonable
7 in relation to cost.

8 Perhaps those were simpler times and one
9 could estimate how much insulin should cost, and
10 the experimental cost of producing -- the discovery
11 of insulin is very small compared with the cost of
12 some of the discoveries that are made today, but
13 there again, I think it is beyond my accomplishments,
14 as financing, taking in cost accounting and everything --
15 I am not trying to avoid the question. I just don't
16 know.

17 MR. RICE: Have the members any questions?

18 MR. WHITE: I would like to ask one question.
19 Early in your presentation you said that there was
20 some first rate literature coming to the doctors, and
21 also some highly questionable literature. Would
22 you tell us a little more about the highly questionable
23 literature?

24 DR. MACDONALD: Well, claims are made for
25 the usefulness of the drug and the conclusions are
26 not based, insofar as the literature concerned would
27 tell you, on solid facts. In other words, if somebody
28 says to me that preparation X is the best thing
29 that ever came out for pernicious anemia, and then
30 gives eight or ten examples perhaps from a hospital



1 that couldn't be identified, or from somebody you
2 never heard about, and you look at it and it's like
3 examining a witness, those of you who are legally
4 trained you know that evidence has to be tested; they
5 don't give you an opportunity to test the evidence;
6 just suggest that you try it and it may be put in
7 a very attractive form with all the arts of the
8 advertising man. I call that highly questionable.

9 MR. WHITE: Does some of the highly questionable
10 literature come from reputable drug houses, or is
11 it from unethical firms?

12 DR. MACDONALD: I suppose if it came from
13 the so-called ethical drug houses, they wouldn't be
14 ethical.

15 By and large, the big drug houses send out
16 pretty good literature in terms of average - now you
17 will disagree, you may disagree with the findings
18 but they give the facts. I will get up at a meeting
19 and say the treatment of this disease should be by
20 A, B, and C and one of my friends will get up and say
21 that is silly. A B and C are no good at all, but
22 in my experience -- nobody can take my experience away
23 from me and I believe -- I may be wrong but I believe
24 it.

25 MR. WHITE: Some of the biggest houses in
26 the States were accused of deliberately falsifying
27 their advertising.

28 DR. MACDONALD: Yes, I know. I haven't gone
29 into that quite frankly. Most of this, I would think
30 that about 85 per cent of this literature is tossed



1 in the waste basket. It is a very great nuisance.
2 The secretary in some offices spends half an hour
3 a day sorting out this mass of samples and literature
4 but some of them I go out of my way to save, tell
5 the secretary to save them because I look through
6 them and some of the stuff is very good and it may
7 not be pushing their own product at all. Just builds
8 up good will.

9 Some of them have some very good articles;
10 may not mention their own product, or if they do
11 mention it, it is mentioned in a reasonable way.

12 MR. PRICE: Earlier we were talking about
13 the detail men and their function and usefulness
14 in the selling of drugs and informing the doctors
15 of the various tests on the drugs that are put out.
16 I would think the doctors are going to rely a lot
17 on what the detail men told them rather than on
18 some literature that they might get in connection
19 with drugs that it perhaps would not know too much
20 about, if it is prepared by an advertising man and
21 it may be very skillfully prepared, very convincing
22 but I think to a large extent you would have to rely
23 on detail men rather than what you might read in some
24 pamphlet.

25 DR. MACDONALD: I wouldn't agree with you
26 sir. I think that probably be very unwise to rely,
27 and I am using "rely" not in an offensive way, take
28 holus-bolus the statement of a detail man without having
29 some evidence upon which to assess it, and then checking
30 it oneself. Remember, that detail men, like all of us,



1 vary in their abilities and motives and everything else,
2 and we get to know. Some of the detail men are very
3 good indeed.

4 THE CHAIRMAN: Do you interview them yourself
5 doctor?

6 DR. MACDONALD: I do some of them but it is
7 a waste of time to see a good many of them and some of
8 them I wouldn't see at all after one experience.

9 That again has to do with the individual
10 concerned; more personal thing than anything. At
11 the end of a long day you don't want a lecture, you
12 want a semi-informed person. That is what it boils
13 down to. Mind you, medical literature, the best
14 medical journals will have a description of the disease
15 and will take the experience of one disease, there
16 may be a hundred cases or two hundred cases, the
17 doctor writes down their experience. They give all
18 the evidence they have. An experienced person can
19 read that literature and say they made a mistake
20 here, and they put too much weight on this evidence,
21 and they accept it as fact what should have been
22 recognized as opinion, and they built their whole
23 case on faulty evidence, just like circumstantial evi-
24 dence in a murder case in a way. Can get away off
25 the beam and from a scientific point of view one
26 has to be critical and I say to interns never believe
27 what you hear. Look at it and examine it and be
28 from Missouri, if I may use such a vulgar expression
29 in this Committee, and find out for yourself.

30 MR. WREN: One witness this morning told us



1 that one of the factors in the high cost of prescriptions
2 could be a doctor who prescribed 20 pills where perhaps
3 five would suffice. Do you think that doctors would
4 be subject to that kind of error very often?

5 DR. MACDONALD: I think that we do fall
6 into that error partly because we don't or can't
7 assess equitably how long a cure is going to take.
8 Certain conditions, for instance, like a person who
9 has had heart failure and has an erratic heart action,
10 and prescribed digitalis for her and you know that
11 is going to be for the rest of her life and prescribe
12 enough so it will be fresh, may presume two months
13 or three months. You don't want to put the patient
14 to the expense of coming back for an examination unless
15 it is necessary.

16 Sometimes you say, well I will give you
17 three months supply. Telephone me in three months
18 and I will see whether I need to see you again, but
19 I can assure you when I say to the patient that you
20 are going to need this drug, I will have to prescribe
21 more for you -- there are other drugs, particularly
22 those dealing with acute infection that we don't
23 know whether a person for instance, is going to need
24 penicillin tablets for four days or fifteen days so
25 there is a tendency perhaps to prescribe a little
26 more than is necessary than a little less than is
27 necessary, and also I suppose there is a human feeling
28 for the druggist. You don't like to prescribe five
29 pills and have the druggist deliver 9 o'clock at
30 night, on a rainy night, knowing his expenses for



1 delivery, are rather heavy too. All these factors
2 enter into it.

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1 The next thing is that some people go for
2 medicine, particularly if they are getting it free
3 and they either do not use it or they are apprehensive
4 people who always want to have a two or three week
5 supply on hand. They go to the doctor and say, "My
6 pills are going to be finished by tomorrow, I need a
7 prescription repeated." The doctor may not remember
8 when he gave the first prescription. There are a good
9 many factors again having to do with the vagaries
10 of human nature.

11 THE CHAIRMAN: Just to complete the record,
12 Dr. Macdonald, as a doctor in what category does
13 your interest lie? In the field of medicine or
14 surgery?

15 DR. MACDONALD: The field of internal
16 medicine.

17 THE CHAIRMAN: Are there any questions from
18 any interested party to this hearing? Are there
19 any other questions?

20 MR. WHITNEY: Mr. Chairman, I would like to
21 ask a question. I understand that some patients go
22 to the doctor and ask for penicillin because they take
23 it for granted that penicillin will clear up an
24 infection of some type. Now, there have been cases
25 of penicillin poisoning. Is it true that at some
26 time there has been indiscriminate use of these drugs
27 or the doctor has given way to the patient's request
28 and it would be preferable if they had not had the
29 previous dosage of penicillin. What I am getting at
30



1 is the tendency to use these drugs regardless of
2 whether they are really necessary.

3 DR. MACDONALD: I am sure that that is so
4 but could I elaborate a bit? Again, human nature
5 being what it is, it is a very difficult situation
6 from a doctor's point of view when he sees the person
7 who is seriously ill or with a high fever and the
8 fever is obviously due to infection and he does not
9 know what the infection is. In this case it is very
10 difficult from his point of view because he wonders
11 whether this is some deep-seated infection that may
12 be mortal. That, of course, is not often the case.
13 Often the situation is that relatives feel that some-
14 thing must be done. Now, it is easy enough for me with
15 the hospital around me and the protection of age around
16 me to say, "Well, I think you should give the Lord a
17 chance and your son or daughter will get well. I am
18 not going to fight nature by prescribing any drugs
19 except acetylsalicylic acid to make him comfortable
20 and good nursing with lots to drink will do the trick
21 and I will watch the complications." They may be
22 quite amenable but it is a different kettle of fish
23 for someone who is 25 years younger than I am and
24 just starting out. You come up against a very
25 aggressive relative who may have read lay journals
26 and know an awful lot or think they know an awful lot
27 about it. We teach that antibiotics are grossly
28 overused from the point of view of expense and we
29 also teach that antibiotics are grossly overused from
30



1 the point of harm. Some antibiotics change the
2 intestinal tract and a person may get diarrhea and
3 a diarrhea that may be mortal. We know that happens
4 but that is a combination of human beings getting
5 together and arguing with each other. The patient
6 has an influence on the doctor psychologically because
7 we want to make people better. Often people do not
8 have enough faith in nature. We know that people
9 used to get better before the days of antibiotics.
10 Antibiotics should be used when there is a likelihood
11 of them being effective. However, you do not use
12 a 16-inch naval gun to shoot down a boat but if you
13 want to sink the rowboat there are other ways of doing
14 it. You do not use an elephant gun to shoot a
15 partridge even up at the head of the lakes.

16
17 This is a very difficult problem and it has
18 to do with all of us being human beings. I face that
19 issue again in consultation. A few weeks ago I stopped
20 an antibiotic and for about four days I had horns and
21 a tail as far as certain people were concerned. I was
22 a very bad fellow just gambling with a person's life.
23 Now, I can stand that but I was in a fortunate position.

24 MR. WHITNEY: What I was referring to is
25 that I know of some people who have a cold or anything
26 like that and they go to the doctor and ask for some
27 kind of shot and that clears it right up. I was
28 wondering if there could not be something done to
29 circulate this fact that there is a danger in the use
30 of antibiotics.



1 MR. MACDONALD: Well, we are doing that.

2 I am not so sure we have not got some comments about
3 antibiotics in this course that is coming on in
4 October. Yes, here we have "Antibiotics and
5 Paediatrics". I am sure the speaker there will stress
6 the fact that you use an antibiotic when you think it
7 is necessary and it is only when your back is to the
8 wall and you think it may be infection that is lethal
9 that you give an antibiotic blindly. The way to
10 use antibiotics is to use the right one for the right
11 bug, that is the idea and that is what we try to teach.
12 Does that answer the question?

13 MR. WHITNEY: Yes, it does. I do know of
14 cases where this poison occurred and I knew it was
15 cases where they had had repeated shots of penicillin.
16 I think perhaps the general public is of the opinion
17 that these are wonder drugs and there is no use getting
18 sick for a week, all you have to do is go to the
19 doctor and it will be cleared up the following day.
20 The general public does not seem to appreciate the
21 danger although the medical profession should.

22 DR. MACDONALD: Well, the medical profession
23 does. However, the modern tendency of every one of us
24 is to do something. The only thing that people will
25 really accept is that the Lord won't change His
26 timetable in terms of human gestation; they will
27 accept that if a lady is pregnant it will take a
28 certain fixed period of gestation, the same since
29 ancient times. However, they feel that if grandmother
30



1 had a cold she may have had it for a week that
2 is no reason that they should have it for a week.
3 They think it should be cleared in 24 hours but it
4 is not. Antibiotics do not change that and we know
5 that but you can teach it until you are blue in the
6 face. It is not all the doctors that are responsible,
7 it is a combination of the people together. "I will
8 do something for you and penicillin won't do you any
9 harm", and it does not in some cases because it is a
10 wonderful drug, the best we have really. You are
11 always fighting a tough battle with medicine.
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28 --- (Page 617 follows.)
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2 MR. SUTTON: In the case of a very high
3 priced drug does the manufacturer through these detail
4 men, give the doctor a supply of these pills to give
5 to a patient who is unable to pay for the prescription,
6 or if the doctor does not keep it in his own office,
7 is it true that the doctor will prescribe these high
8 priced drugs and say you go to a certain druggist
9 and you will get it free because they have a supply?

10 DR. MACDONALD: I don't know about that,
11 but I do know in the case of some expensive drugs,
12 even after they have been proven useful, it is
13 possible to get a supply, but you do not get it from
14 the retail pharmacist. You get it from either the
15 detail man or direct from the manufacturer.

16 It is not every doctor that can do that
17 because the manufacturers now just as the question
18 was raised by Mr. Whitney -- is it Whitney? --
19 the manufacturers now just as Mr. Whitney well knows,
20 some people feel they should be using antibiotics
21 and it is very expensive, and it is not necessary, but
22 they will if a doctor whom they know and whom they know
23 does critical work -- that is critical in the sense
24 of being discriminatory -- they will give them some.
25 I have had drugs given to me by manufacturers, and
26 sent a missionary back to Portuguese West Africa last
27 winter with 800 or 900 tablets of a new preparation
28 that the manufacturer gave them and they couldn't
29 afford it.
30



1
2 MR. WHITE: Doctor, I am told by a man
3 whom I trust implicitly that commissions are now paid
4 by druggists to doctors on prescriptions that the
5 doctors order, and I am told by other men that I trust
6 equally that the practice is fairly widespread in
7 other parts of the province, particularly in small
8 localities.

9 We are concerned here with the cost of drugs,
10 and I am wondering, first of all, how wide spread the
11 practice is of druggists paying commissions to doctors
12 and secondly, how much that might add to the drug
13 costs, and what if anything is the profession doing
14 to stamp out that practice, or perhaps it is considered
15 ethical, I don't know.

16 DR. MACDONALD: Well, I would think that
17 the doctor who took commissions under those circumstances
18 would be beyond the pale. I don't know of it. I
19 don't honestly know of it. I never heard of it, and
20 it never occurred to me it would occur.

21 I think the doctors taking samples and using
22 them and selling them is just about as bad. In other
23 words, samples should be reserved for careful clinical
24 trial, of if they are proven useful, they should be used
25 for patients who can't afford to pay for them or who
26 it would hurt to pay for them.

27 To return to this other thing, I would think
28 if that practice can be shown to have occurred and it
29 would probably be very difficult to find out about it,
30



1
2 that would be a matter for the Ontario College of
3 Physicians and Surgeons.

4 I think it is highly immoral. There is a
5 conflict of interests right away. If I am going to
6 prescribe a drug that costs \$20.00, and I know there
7 is one that can be bought for a dollar and I get a
8 commission on the twenty, and am low enough to take
9 the commission, what am I going to prescribe?

10 MR. WHITE: Well, Doctor, have you not
11 heard that is being done?

12 DR. MACDONALD: I have never heard that,
13 no.

14 MR. WHITE: The information was given
15 to me in confidence by accountants who had audited
16 the books of drug stores.

17 DR. MACDONALD: I think they are lying
18 down in a pretty messy stable then, to be quite vulgar
19 about it. I think if that does exist it would be an
20 awfully good thing for this Committee to draw
21 attention to it, because it would be on the shoulders
22 of the disciplinary body to deal with it.

23 Medicine is difficult enough under the best
24 of circumstances. We have to make decisions that are
25 often on the basis of probability, and we cannot be
26 influenced at all.

27 MR. WREN: What is the ethical position
28 of a doctor who owns a drug store and practices in
29 the same neighbourhood?
30



1
2 DR. MACDONALD: I don't know. I would
3 think that is unethical. If he has to, in the location
4 he is in or grew up in, under those circumstances,
5 I think he would be honour bound to make sure that his
6 patients weren't paying a big premium for drugs to him.
7 That is my feeling but that may be a rigid Presbyterian
8 attitude, I don't know.

9 THE CHAIRMAN: Any other questions, gentle-
10 men?

11 MR. D. WALMSLEY: (Representing Squibbs)
12 Doctor, I don't know whether this is a good
13 question, but when a prescription is being written and
14 given to a patient to take to a drug store, is the
15 practice ever followed that there are marks on the
16 prescription that can only be interpreted -- are only
17 intended to be interpreted by one particular druggist
18 in a drug store in the vicinity?

19 DR. MACDONALD: I don't know that.

20 MR. WALMSLEY: It is in connection with
21 the same thing that Mr. Wren referred to.

22 DR. MACDONALD: I don't know.

23 MR. WALMSLEY: As far as you know the only
24 indications on the prescription are as to the content
25 of the preparation?

26 DR. MACDONALD: What did you say?

27 MR. WALMSLEY: Remarks that could only be
28 interpreted ---

29 DR. MACDONALD: You said as far as I know?
30



1
2 MR. WALMSLEY: As far as you know.

3 DR. MACDONALD: Well, it is not a question
4 of "as far as I know". I do know that there is not,
5 and I don't know of any of my friends who do that.
6 Of course, I don't know all the prescriptions they
7 write, but I just assume they wouldn't. I think
8 that again raises the question of conflict of interest.

9 Our business is to deal with -- to do what
10 a patient wants to do as far as illness is concerned
11 and get a fee for our opinion and advice, but not to
12 get a fee for anything else, or a commission.

13 THE CHAIRMAN: Well, Doctor Macdonald,
14 may I say this to you for the Committee, that you have
15 been very frank and forthright in your statements to
16 us which we appreciate, particularly in the light of
17 some points which have been raised. We thank you for
18 the approach you have taken today. No wonder you
19 occupy such a high position in your profession.

20 DR. MACDONALD: Thank you very much, sir.
21 I will leave these with the Secretary if you are
22 interested.

23 THE CHAIRMAN: We will adjourn until
24 10 o'clock tomorrow morning.

25
26 --- Adjournment.
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Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO ONTARIO

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Wednesday,
the 5th of October, 1960, at
10.00 a.m.

COMMITTEE:

MR. H. L. ROWNTREE, Q.C. Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G. F. LAVERGNE

MR. S. J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A RICE, Committee Counsel



1 ---On resuming at 10:00 a.m. October 5, 1960.

2 THE CHAIRMAN: Gentlemen, are we ready to
3 proceed? Professor Fuller and Mr. Rice.

4 PROFESSOR HORACE J. FULLER (called)

5 MR. RICE: I believe that you ended your
6 examination yesterday explaining to the Committee
7 the difference between the price of a new prescription
8 and a repeat prescription. Was there anything further
9 you would like to add?

10 PROF. FULLER: Oh yes. There is another
11 reason for the differentiation in price. Many of
12 the new prescriptions today are for medicinals that
13 are called schedule drugs, the nature of which Dean
14 Hughes pointed out in his original submission.

15 In many cases of these schedule drugs, the
16 prescription can be filled only once and the patient
17 must go to the doctor and get a prescription each
18 time. Very often those are for the newer drugs,
19 tranquillizers and antibiotics and so on, and they
20 are naturally a little higher in price than some of
21 the older type prescriptions that do not need a new
22 prescription each time. That is possibly one of the
23 reasons.

24 MR. RICE: Is there a practice among pharma-
25 cists to give a repeat prescription at a cheaper
26 price than the original prescription?

27 PROF. FULLER: I have never heard of that.
28 The original price is marked on the prescription as
29 a rule when it is filled, and that price stands
30 through the years until it becomes out of date or if



1 it has to be raised.

2 THE CHAIRMAN: Or reduced, now, Professor
3 Fuller?

4 PROF. FULLER: I beg your pardon?

5 THE CHAIRMAN: Or reduced?

6 PROF. FULLER: Or reduced, yes.

7 THE CHAIRMAN: Because, am I not right that
8 when drugs are first patented and after the research
9 costs are incurred, the price will be higher. As the
10 drug becomes in longer use, we would expect the price
11 to be lowered.

12 PROF. FULLER: Oh yes, that is true in many
13 cases.

14 THE CHAIRMAN: Isn't it true in all cases?

15 PROF. FULLER: May I submit this --

16 THE CHAIRMAN: Isn't it true in all cases?

17 PROF. FULLER: The price of the drug would
18 come down, the price of the prescription would come
19 down a certain extent.

20 THE CHAIRMAN: On a descending scale?

21 PROF. FULLER: On a descending scale.

22 THE CHAIRMAN: That is correct, over a
23 period of years or months?

24 PROF. FULLER: Yes.

25 THE CHAIRMAN: And that is not to be confused
26 with an ascending scale of rising costs?

27 PROF. FULLER: No.

28 THE CHAIRMAN: Or any other fact or cost
29 of living which we might expect to be rising? I
30 want to make this point clear, that the cost of drugs,



1 the longer they are in existence, we would expect
2 them to be on a continuous descending scale of price,
3 is that right or wrong?

4 PROF. FULLER: That is right. May I quote
5 some figures, about four lines here from the American
6 Druggist that came in yesterday afternoon? The editor,
7 since 1952 has kept score of drugs of 3548 price
8 changes. Of these, 1,226 were upward changes while
9 2,322 were downward changes.

10 THE CHAIRMAN: Have you any information to
11 amplify that?

12 PROF. FULLER: It is simply that the editor
13 of the American Druggist started to keep score of
14 these in 1952. That is the only information I have.

15 THE CHAIRMAN: Of your own knowledge, you
16 don't have any information on that?

17 PROF. FULLER: No. Take penicillin and
18 cortisone. The prices are ridiculously small in
19 comparison with what they were when they first came
20 out.

21 THE CHAIRMAN: Would you like to amplify
22 that a little bit? Are there some other reasons for
23 that, Professor Fuller?

24 PROF. FULLER: As the demand increases for
25 a drug, naturally more manufacturers attempt to make
26 it, and they introduce mass production methods and
27 savings in the method of making it, and the number
28 of steps in making some of these complex chemicals
29 has been reduced tremendously, sometimes cut in
30 half just through pure research and so on, on how to do



1 it.

2 THE CHAIRMAN: What about the effects of
3 licensing of patents?

4 PROF. FULLER: Pardon?

5 THE CHAIRMAN: Do you know anything about
6 the effect of licensing of patents?

7 PROF. FULLER: I am sorry I know nothing
8 about that.

9 THE CHAIRMAN: I am going to suggest to
10 you that the terms of the licensing contract may
11 have a very direct bearing on what the ultimate
12 price is.

13 PROF. FULLER: I am not familiar with that,
14 sir. It is not in my field.

15 THE CHAIRMAN: It has to do with some of
16 the drugs you mentioned a few minutes ago. Do you
17 recognize what I am talking about?

18 PROF. FULLER: I understand that when a
19 manufacturer applies for a license to produce a
20 product, that originally was patented by someone
21 else, there is a contract agreement that is to some
22 extent - just how I do not know - supervised by the
23 government, and the terms are set forth in the agreement
24 or contract. Just exactly the nature of them, I do
25 not know.

26 THE CHAIRMAN: Depending on what the terms
27 of that licensing agreement would be, might have an
28 effect on the ultimate selling price?

29 PROF. FULLER: Yes. It might. I agree with
30 that.



1 MR. SUTTON: What do you mean when you say
2 "Supervised by the government"? When you said agree-
3 ments between different manufacturing concerns are
4 supervised by the government, what did you mean?

5 PROF. FULLER: I must plead innocent. That
6 is entirely out of my field and I have given to no
7 study at all.

8 I think it originated during the War in the
9 United States, where certain firms had the sole right
10 to make medicinal agents that were required by the
11 Armed Forces, and the government broke open the patent,
12 as it were, and forced the license, enabling other
13 manufacturers to make the same product under license
14 under the supervision of the government.

15 The anti-malaria drug was perhaps the
16 outstanding example of that. Originally the Winthrop
17 Chemical Company, I believe, had the patent rights
18 on it, and the American government licensed the
19 Merck & Company to produce it and others. That is
20 where it started.

21 The same plan has been adopted in Canada.
22 That is frankly all I know about it. It is a big,
23 broad statement, the details of which I have no know-
24 ledge.

25 MR. BOYER: Does that policy still continue
26 in the United States?

27 PROF. FULLER: As far as I know. I think
28 you have an illustration of it in the pharmaceutical
29 field. I remember reading in the paper in the last
30 few weeks where the Borden Company applied for permission



1 to make or process mashed potatoes by the process
2 now being used by the Sheriff Corporation and the
3 Court denied them the privilege.

4 MR. SUTTON: Those companies that you spoke
5 of, were they companies that were taken over by the
6 United States government, were they not German companies
7 that were taken over by the government because they
8 had such valuable patents and discovered wonder drugs,
9 and the government permitted other companies to make
10 the same drugs.

11 PROF. FULLER: I knew a lot about it 15 years
12 ago but I have forgotten the details of it. The
13 Winthrop Chemical Company, as I remember it -- I may
14 be entirely wrong -- was never taken over by the
15 American Government, but some of the shares of stock
16 of the Winthrop Chemical Company were owned by
17 General Aniline and Film Corporation. General
18 Aniline and Film Corporation was taken over by the
19 American Government to that extent, and what the
20 legal device was to turn over the manufacture, I do not
21 know. But I do know the assistant to the president
22 said they did not divulge all the secrets they had.

23 MR. WREN: I am not familiar with all the
24 drug terms, Prof. Fuller, but last night a medical
25 doctor was telling me about a drug which he was using
26 in the treatment of local disease. It is a wonder
27 drug. Would it be streptomycin?

28 PROF. FULLER: Streptomycin has been used.
29 I am not familiar with the terms, either. As I mentioned
30



1 yesterday at one time in the early '30's , I did teach
2 pharmacology for five years, but so many new drugs
3 and new methods have come in since that time, I am not
4 familiar with all of them.

5 MR. WREN: In any event, he drew a comparison
6 between penicillin and its high cost when it was
7 first brought on the market, and its relatively minor
8 cost today, with this other drug that was brought out
9 ten years ago at \$9.50 for 25 tablets. Despite the
10 fact that the use of this drug is very widespread,
11 over the ten-year period the cost remains at \$9.25
12 per 25 tablets.

13 PROF. FULLER: That might be possible, but
14 I say as far as the economics of manufacturing are
15 concerned, I am completely ignorant of that area of it.

16 MR. WREN: He also told me that he or
17 any druggist could obtain drugs at wholesale prices
18 from drug houses under certain circumstances, of course,
19 and the common practice was the druggist was familiar
20 with the mark-up of 100 per cent on them. It was a
21 common practice. Have you found that in any of the
22 reports or discussions you have had with pharmacists?

23 PROF. FULLER: That is the thing that stirred
24 the rumpus in the United States originally. An
25 economist by the name of Blair, before the Kefauver
26 Committee, came up with an outlandish percentage of
27 mark-up in drugs, The percentage can be calculated
28 in two different ways.

29 In business and society, the mark-up is
30



1 calculated as a percentage of selling price for the
2 reason that you don't make it until you sell it.
3 On that basis it is impossible to make 100 per cent
4 profit. If you bought something for 1 cent and sold
5 it for \$1 million, the percentage gross margin would
6 still be 99.999 -- infinity.

7 MR. WREN: I can understand that, but what
8 the gentleman meant was for example where the
9 wholesale cost was \$1, the retail price automatically
10 became \$2.

11 PROF. FULLER: I tried to explain that
12 yesterday with the overhead expense to the pharmacist
13 if the ingredients cost \$1, the cost would be \$1.10.

14 MR. WREN: That is 'not taking into account
15 overhead, prescription compounding costs, or anything
16 else. It is just the cost factor of the drug itself.

17 PROF. FULLER: I don't quite understand
18 what you mean. If he paid \$1 for it he dispensed it
19 for \$2 --

20 MR. WREN: If he paid \$1 for it, he would
21 charge \$2 plus his overhead and other expenses.

22 PROF. FULLER: I would not agree with you.
23 He would perhaps charge \$2 plus a 75-cent dispensing
24 fee. It might be a little higher in cases where
25 there were broken packages. If a medicinal came in
26 packages of 40 tablets, and the doctor prescribed 24
27 tablets, what is he going to do with the remaining 16
28 tablets? If he calculates the cost of the tablets on
29 the basis of 24/40's of the price of the original
30



1 package and adds his overhead of 39 cents, and the
2 other 16 tablets remain on the shelf after the package
3 has been broken, and he cannot give a prescription for
4 them, that package might ultimately go down the sewer.
5 In the meantime it is "profit" and it is reported to
6 the income tax people and he pays the income tax on
7 it. He might get a little bit more for a broken
8 package.

9 In Massachussets at the present time
10 the Welfare Department of the State have signed an
11 agreement with the State Pharmaceutical Association,
12 that if the package is broken they allow them to
13 add an additional dollar for the broken package.

14 MR. TROTTER: When you say they get more for
15 a broken package, I have here a set of fees that the
16 druggists receive. I think this is set by the College
17 and according to these rates I have here, if a
18 druggist pays \$7 for 100 tablets, they set out the
19 rates that he should charge.

20 For example, if he buys 100 tablets for
21 \$7 and he sells them in the package of 100, he is
22 to charge \$7.75 which seems quite a very fair price.

23 MR. FULLER: Yes, I would say in answer to
24 your last question first, \$7 is the list price and he
25 adds 75 cents as a professional fee, making it \$7.75.

26 I would like you to clarify your other
27 statements further. I think this is in use by 50 per
28 cent of the pharmacists in Ontario. I would say that
29 50 per cent or more charge prices that are lower
30



1 than that. Secondly, it is only a suggested method.

2 MR. TROTTER: Just the same, that is not
3 my point actually. If he sold it in bulk as he bought
4 it, I realize the price would be very fair.

5 Our problem has been that so many people
6 cannot afford to buy 100 tablets at a time, that they
7 buy in small quantities, broken packages, and this
8 is where the pricing of your College is the one that
9 is recommended. I do not know if the druggists use
10 it or not.

11 THE CHAIRMAN: What is the cost of that?
12 What is the profit?

13 PROF. FULLER: I just gave it in round
14 figures.

15 MR. WHITE: That is less a discount?

16 MR. TROTTER: Yes, that is the list price,
17 because \$7 is what the druggist pays to the manufacturer,
18 \$7 per hundred tablets.

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20
21
22
23
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26 --- (Page 633 follows.)
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29
30



1 MR. WHITE: What is the discount? Is it
2 50%?

3 PROF. FULLER: No, 40.

4 MR. TROTTER: Now if the druggist is to sell
5 say six tablets, if a purchaser comes in to buy six
6 tablets, \$1.65 which if he could divide the six tablets,
7 at least the 100 tablets it would be over 16 times
8 what he gets.

9 In other words, if he could sell off his
10 100 tablets in groups of six, he would get \$112 for
11 his original \$7 investment. Of course, I realize
12 there is overhead yet the more you buy the more value
13 you get. In other words, if you get 10 tablets instead
14 of 6, you would pay \$2 for the 10 tablets, and in that
15 way the druggist doesn't make quite so much, but
16 certainly it is an extremely high rate.

17 Our problem is that the average person has
18 to buy in small lots, so a small person gets stung.
19 Don't you think these rates are extreme in that
20 regard?

21 PROF. FULLER: I would like to answer all
22 your questions at a little bit of length.

23 1: I do not represent the Ontario College
24 of Pharmacy. 2nd: I have had nothing to do with the
25 preparation of that schedule, outside of putting
26 some of the figures on my calculating machine for the
27 Committee that was involved. 3rd: The number of
28 tablets that the patient receives is a responsibility
29 of the prescribing physician. If a doctor prescribes
30



1 100 tablets, that is what the doctor wants the patient
2 to have.

3 If he prescribes 50, that is what he wants
4 the patient to have. What he wants and prescribes,
5 that is the responsibility of the physician. As I
6 pointed out yesterday, in dispensing every prescription
7 there is a cost of at least \$1.10.

8 Let's go back to the crane operator in the
9 Port of Montreal. If you have an investment in the
10 crane, you have the operator's time; if he has to
11 lift a ton of cotton or anything out of the hold of
12 the boat in 10-lb. lots, 10 lbs. at a time rather
13 than the whole ton at a time, quite obviously it is
14 going to be a fairly expensive unloading procedure
15 and the same thing is true here. The cost was \$1.10
16 every time he fills a prescription whether it be for
17 six or six hundred. Therefore, it is not an exorbitant
18 price, it is simply paying the costs of the
19 pharmacist.

20 MR. TROTTER: All I was interested in were
21 your views because it seemed extreme. Admittedly,
22 to a person who buys 100 the price is fair but it is
23 the small purchaser; that still seems an extremely
24 high rate despite the cost of packaging. Just an
25 instance where the small man pays.

26 PROF. FULLER: Yes. I would say that I
27 could see how the little fellow would think that it
28 was an extreme price, but certainly the pharmacist
29 has no control over it, and as I tried to point out in
30



1 my submission yesterday, the pharmacist cannot possibly
2 recover his overhead cost, or some sort of a percentage
3 mark-up on 6 tablets.

4 That is where he has been losing money.
5 On 46.3% of his prescriptions he has been doing that,
6 feeling that these people cannot pay as much and
7 therefore give it to them for so much and he is losing
8 money on it and then he must make that up on other
9 prescriptions or on the sale of toys and ice cream
10 and other things.

11 MR. TROTTER: I would like to ask the
12 witness this question: people who suffer from
13 arthritis or who have diseases from old age, do they
14 not have to take drugs all the time? Once you start
15 taking these pills must you not keep buying?

16 PROF. FULLER: Well, I presume that in some
17 cases they do. Not being a medical practitioner I
18 couldn't answer a straight yes or a straight no to that.
19 They may take them for a period of time and then stop,
20 and then they have to take them all their life.

21 The thing is, because we have these situations
22 and we have the indigent and we have problems of
23 elderly people, and retired people, we do not pull
24 down the whole price structure because of that situation.

25 This was in the paper late in July of this
26 year:

27 "The average cost of a house in Metropolitan
28 "Toronto has increased \$300 a year since
29 "1953 and the rise will continue into next
30



1 "year, A. W. Treleaven, General Manager of

2 "the Toronto Real Estate Board predicts."

3 So seven years later, the house has gone up \$2,100.

4 In seven years elderly people must live in a house
5 the same as young people will. We don't have to pull
6 down the whole price structure of real estate for the
7 sake of the indigent or aged, and I feel it is the same
8 way as far as drugs are concerned that there may be
9 a solution if the Government would, as they do in,
10 I believe, Australia, make up a list of what they call
11 life-saving drugs and these drugs are free to every
12 citizen of Australia regardless of his economic status.
13 By agreement with the Government, the pharmacist fills
14 the prescription at a stated price and sends the bill
15 to the Government. Whether the patient be a millionaire
16 or a stumblebum he gets it free of charge in this
17 restricted list and that to me seems a very adequate
18 way of looking after this situation without destroying
19 the whole price structure.

20 MR. TROTTER: Do you think from your knowledge
21 of the drug market that the way of marketing drugs,
22 say under the Windsor Plan a good idea? Both fair to
23 the druggist and fair to the public?

24 PROF. FULLER: I wish you hadn't asked that
25 question. Bill Wilkinson is a very good friend of mine.
26 I do not agree with his plan at all. He is perfectly
27 aware of it, and he knows the reasons why.

28 I have put my reasons in print, or in public
29 before the New York State Pharmaceutical Association,
30



1 by request, a year ago last June. My reason against
2 this scheme is that the scheme is not practicable.
3 One, that the prescriptions in the first place are not
4 soundly priced when we realize that 46.3% of the
5 prescriptions now dispensed are dispensed at a loss.
6 If that situation goes on, then the pharmacist is
7 frozen in that plan by subsidizing, what to me perhaps
8 might eventually become a government function.

9 The rates that the Windsor Plan are charging
10 are at least twice what statistics show to be the
11 average amount the average family spends on prescribed
12 medicines in a year. You take out fire insurance
13 on your house, and the premiums are relatively low
14 for a large amount of risk. Perhaps for \$50 or \$60,
15 roughly, I don't know, over a period of three years
16 you can insure your house against \$10,000 fire.

17 The difference between what you can pay now
18 for what is a known loss, and the unknown -- and the
19 possible loss in the future is great -- there is
20 something to be gained but why should you pay \$50 a
21 year when the average family -- in insurance rates --
22 when the average family spends only \$25 on prescribed
23 medicine. The result is what my friend Mr. Wilkinson
24 himself as of August 16 of this year in Saskatoon,
25 Saskatchewan, Mr. Wilkinson told me that he had 1100
26 bodies in his scheme and "bodies" is a term that he
27 used.

28 MR. TROTTER: Isn't it a satisfactory scheme
29 as far as the druggists in Windsor are concerned, and
30



1 also the public?

2 PROF. FULLER: I don't know how you measure
3 the term "satisfactory". It isn't a scientific term,
4 of course. The number of prescriptions -- I have
5 forgotten just how many were filled in the first year,
6 but as I remember it, it amounted to 34 prescriptions
7 for each one of the 75 pharmacies in the scheme.

8 About 100,000 people in Windsor and here
9 the pharmacist is getting one prescription -- 34
10 prescriptions, less than one a week, as a return on an
11 initial investment in the plan at \$150. Who is it
12 satisfactory to?

13 MR. TROTTER: Well, what I mean by satisfactory
14 the druggists are making a good living and the public
15 are getting drugs they need at a price they can pay,
16 and the Windsor Plan seems to be working out.

17 PROF. FULLER: I wouldn't say that at all.
18 The pharmacists at Windsor each put up \$150 to start
19 the Plan going. The Ontario Retail Pharmacists
20 Association subsidized it further a year ago with
21 \$3,000 for the pharmacists to get a normal price back
22 on 34 prescriptions a year. It is costing
23 him \$5 almost in getting back a profit on 34 prescrip-
24 tions, multiplied by 39 cents. Doesn't seem to be
25 rational, from my point of view.

26 MR. RICE: Professor, could we have some
27 other words on this repeat prescription. How old is
28 a prescription, in your statistics here when you
29 include it as a repeat prescription?
30



1
2 PROF. FULLER: I haven't the faintest
3 idea. I remember back - I haven't worked in a
4 retail pharmacy for many years, I can remember back
5 in what we called the good old days in Hamilton, the
6 late Major-General Mewburn just before the war, he
7 had a prescription for cold tablets No. 65 put out
8 by Parke-Davis and Company, 18, I have forgotten the
9 directions, we charged him 35 cents and every friend
10 he saw in Hamilton that had a cold, he told them the
11 prescription number and to go into Drewery's and get
12 that prescription. For years we filled that thing
13 two or three times a week, and all such things as
14 that; might be a prescription that we fill ten years
15 after.

16 It isn't a good practice at all because the
17 patient should go back and consult the physician.
18 One of the reasons in the Saskatchewan Plan, Saskatchewan
19 will permit a doctor to prescribe medicine for one
20 month only and will pay for one month only.

21 I have talked to Mr. Brown and talked to
22 others in the Saskatchewan system and their feeling
23 is that it is high time a patient should go back and
24 see a doctor rather than just continue taking certain
25 medication.

26 MR. TROTTER: Does the patient need the
27 doctor's order to get his prescription filled again?
28 This is a scheduled drug, he needs a new order from
29 a physician?
30



1
2 PROF. FULLER: If it isn't what we call
3 a scheduled drug there is no reason why he can't have
4 it repeated unless the doctor has given orders to
5 the pharmacist that it shall not be repeated.

6 MR. TROTTER: Is this prescription fee
7 that you were referring to, is it included in the
8 repeat prescriptions if there is no doctor's order?
9 Just walks in and asks?

10 PROF. FULLER: You mean the 75 cent
11 professional fee?

12 MR. TROTTER: Yes.

13 PROF. FULLER: Yes, he is performing
14 a function just the same as when it was an original
15 prescription. Has to go through the same activity.
16
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18 (Page 644 follows)
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2 MR. RICE: You have anticipated my next
3 line of questioning. Are there any aids to the
4 pharmacists in Ontario in establishing prices for
5 prescriptions?

6 PROF. FULLER: Are there any aids?

7 MR. RICE: Yes, price lists.

8 PROF. FULLER: All I know of is this
9 suggested one that you have before you here. This is
10 merely a suggested list to give them some idea. As
11 I pointed out yesterday, in the training of pharmacists
12 in 1921 the pharmacists was not taught to price a
13 prescription or anything else, he just went out and
14 followed his nose, as it were. Through the years
15 the colleges of pharmacy all over the United States
16 and Canada have tried to teach pharmacists sound
17 economic and business principles. This has been a
18 very slow process. We have tried to get this across
19 to them and to so train them so they will be better
20 equipped when they go out in the world not to be an
21 economic failure. This is only a suggestion and I
22 am very certain at least 50 per cent do not use it
23 but use lower prices. I have had two requests in
24 the last week where people wrote in and asked for the
25 1958 schedule, the one that proceeded that, because
26 they felt the prices were lower and that is the one
27 they wanted to use. Others do not use it at all.
28 Hamilton prices are lower and they do not like that
29 and I think the pharmacists in Windsor are dissatisfied
30 and if they do not like it they do not use it.



1
2 Hamilton does not like it and they have their own
3 scheme. Ottawa, I believe, have their own scheme.
4 As I say, this is only a suggestion and the variations
5 are very slight, perhaps 5 cents or 10 cents on any
6 level.

7 MR. RICE: I notice this one is revised
8 in January 1960, when was it revised prior to that
9 time?

10 PROF. FULLER: I really could not say
11 because I am not on the committee. I have had nothing
12 to do with this except to get a copy of it when it
13 came out. I think the one prior to this was sometime
14 in 1958 but I am not certain.

15 MR. RICE: How long has a price list of
16 this nature been in existence? When did they commence
17 it?

18 PROF. FULLER: I do not know. This is
19 simply to give the pharmacists a guide much like the
20 lawyers have, a book giving a suggested schedule of
21 fees.

22 MR. RICE: But the pharmacist is not
23 bound by it?

24 PROF. FULLER: Not in any way, no.

25 MR. WREN: Are you leaving that part now?

26 MR. RICE: No, I was going to ask if the
27 Chairman wanted to file a copy of this.

28 PROF. FULLER: We have no objection to
29 filing it.
30



1
2 MR. RICE: I was wondering if you wanted
3 to file it as part of your material?

4 PROF. FULLER: I really do not care. I
5 have nothing to do with the Ontario College of Pharmacy,
6 I am employed by the University of Toronto. Every
7 pharmacist in Ontario who practices pharmacy must pay
8 his dues and automatically he is a member of the
9 College. All members of the faculty at the University
10 of Toronto being pharmacists, just because it is a
11 thing to do are members simply through the payment of
12 their dues.

13 THE CHAIRMAN: You might clarify that
14 for the record. Perhaps we are using the wrong term
15 here. The degree of graduate pharmacist is awarded
16 by the University of Toronto through the Faculty of
17 Pharmacy.

18 PROF. FULLER: That is right.

19 THE CHAIRMAN: And what is the provision
20 of the College of Pharmacy?

21 PROF. FULLER: Then the Ontario College
22 of Pharmacy, by virtue of the fact the University of
23 Toronto has granted a degree, they license him
24 according to the Pharmacy Act of Ontario. The Ontario
25 College of Pharmacy is the licensing body.

26 THE CHAIRMAN: Has it any other functions?

27 PROF. FULLER: As I say, I am not an
28 officer of the Ontario College of Pharmacy and I would
29 not like to speak for them. There is a discipline
30



1
2 committee where people are selling things or doing
3 things they should not but they have no function as
4 far as prices are concerned excepted to suggest.

5 THE CHAIRMAN: I think it is best to
6 straighten out the record. This tariff was promulgated
7 by what body?

8 MR. RICE: The Ontario College of Pharmacy,
9 special committee on pricing?

10 THE CHAIRMAN: That is the professional
11 governing body?

12 PROF. FULLER: Yes. I might say this
13 schedule is in Ottawa, they have copies of it for
14 investigation and that sort of thing. They have a
15 full file of the survey that I produced and have
16 written me a very nice letter about getting this
17 material.

18 MR. RICE: Your estimate is that about
19 50 per cent ---

20 PROF. FULLER: If you are going to record
21 it I would like to put it as not more than.

22 MR. RICE: Use this schedule?

23 PROF. FULLER: Yes.

24 MR. RICE: Could you give us any reason
25 why the pharmacists do not go for that schedule?

26 PROF. FULLER: Pharmacists are difficult
27 people to train in the economic sense. They change
28 things very slowly and they appear to be very loath
29 to raise prices, even when good common sense tells
30



1
2 them they should in order to keep their head above
3 water. In one of these surveys - I cannot put my
4 finger on it quickly at the moment - over 25 per cent
5 of the pharmacists in Canada that year of the survey
6 would have been better off if they sold their pharmacies
7 and gone and earned a salary working for somebody else.
8 They would have had more money. One of the reasons
9 why they are in that situation is simply because they
10 have no sound pricing policies. Somebody comes in
11 who can only afford 6 tablets and the tablet costs
12 50 cents and he will sell them at less than that and
13 he will lose money right off. In this prescription
14 survey one prescription in Saskatchewan was filled for
15 15 cents. In the brief we filed there were some at
16 less than 50 cents and some less than a dollar and
17 everytime these prescriptions are filled the pharmacist
18 is taking money right out of his own pocket.

19 MR. RICE: Is there any facility for the
20 return of unused tablets?

21 PROF. FULLER: Not on any broken package.
22 The pharmacist is responsible for what is in the
23 package and the manufacturer too. What could the
24 manufacturer do with it except throw it away or
25 destroy it, after the package seal has been broken.
26 Mrs. Jones gets a prescription filled which costs
27 \$15.00 and after three days she finds she has an
28 allergy to the drug and the doctor tells her not to
29 take any more. She goes to the pharmacist and says
30



1
2 "This cost \$15.00, take it back". If you were another
3 customer would you want a medicine that has been in
4 somebody else's medicine cabinet or would you prefer
5 and unbroken package from the shelves. I think you
6 can see why they cannot take it back. Of course,
7 if Mrs. Jones spent \$50.00 or \$60.00 in the store,
8 it may be discreet to take it back but pharmacists do
9 not make a practice of taking prescriptions back from
10 customers. Likewise, manufacturers do not make a
11 practice of taking back broken packages. It would
12 be very unsafe.

13 MR. RICE: Will manufacturers take back
14 outdated products?

15 PROF. FULLER: I believe some of them will
16 but I know of one who will not. This manufacturer
17 sold a bill of goods to a hospital in Manitoba and
18 they thought they were getting a very good price but
19 when they arrived the dates were long before them.
20 They asked the manufacturer to take them back but he
21 said, "No, you bought it so it is your funeral".

22 MR. RICE: Then the pharmacist runs a
23 risk on a broken package?

24 PROF. FULLER: He runs a very great risk.

25 MR. RICE: Now, to go back to the tariff
26 for a moment. Would you say that some of the pharmacists
27 of Ontario or a large percentage of them are satisfied
28 with the prices they are making - the profits they
29 are making?
30



1
2 PROF. FULLER: I could not say whether
3 they are satisfied with it or not. If they are
4 using it then that is prima facie evidence they are
5 satisfied and if they are not using it it would be
6 prima facie evidence they are not satisfied with it.

7 MR. RICE: And those that are not using
8 it, would you feel they would be charging less than
9 this tariff?

10 PROF. FULLER: I would say that some would
11 be charging more and perhaps a great many are charging
12 less and because they are charging less it gives rise
13 to these statistics I gave for the 41 per cent in
14 Ontario.

15 MR. RICE: Now, Professor, in your brief
16 yesterday you set out in page 32 the three factors
17 that you submit go into the cost of a prescription.
18 The first item was the cost of the ingredients;
19 secondly, overhead factor and the third was a profit
20 to the pharmacist. Is that correct?

21 PROF. FULLER: Yes.

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23 (Page 652 follows)
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1 MR. RICE: Now, I would like to deal with
2 those. First of all the profits. This factor --

3 PROF. FULLER: The which?

4 MR. RICE: The profit factor. This would
5 be completely within the ambit of the pharmacist,
6 whether he wanted to make money or whether he wanted
7 to lose?

8 PROF. FULLER: Yes, that is simply the
9 freedom of enterprise in operating an organization.

10 MR. RICE: So that if that factor affects
11 the ultimate price of drugs, that is completely within
12 the hands of the pharmacist?

13 PROF. FULLER: Yes.

14 MR. RICE: On that profit factor then, I
15 have noted from your average cost of profits of 511
16 pharmacies in Canada, in Ontario there you have a
17 total income of \$15,164.

18 PROF. FULLER: Yes.

19 MR. RICE: And that is compiled of salary
20 of \$9,147, and \$5,678 on investment, and \$339 from
21 other income.

22 Now, dealing with the investment income,
23 you show there a value of merchandise, stock, \$18,798.
24 You show fixtures average value, \$6,671, making a
25 total of \$25,459.

26 Then you show in Accounts Receivable, \$2,401,
27 Accounts Payable of \$5,980. In other words, the
28 difference between these two being financed to the
29 extent of \$3,579. Isn't that correct?

30 PROF. FULLER: Yes.



1 MR. RICE: That would reduce his investment,
2 his \$25,459 to \$21,980?

3 PROF. FULLER: Yes.

4 MR. RICE: And on that investment he received
5 an income, investment income of \$5,678. That would
6 work out to close to 25 per cent, would it not?

7 PROF. FULLER: On investment, yes, but if
8 you want to judge that, I would suggest that you get
9 like statistics for industry. They quote their
10 returns as a percentage of sales, which we have done
11 here. On the percentage of sales, it is not over five
12 per cent, and if you want to say this is high for
13 pharmacy, I would say in all fairness you must look
14 at industry and calculate their profit as a percentage
15 of their investment.

16 THE CHAIRMAN: I think the Committee will
17 be looking at those other figures. We are interested
18 in the answers to the questions which Mr. Rice is
19 asking.

20 PROF. FULLER: I would like to say here
21 as I did in the early part of my paper on the average
22 only 26 per cent of the total receipts of the pharmacy
23 comes from prescriptions. These other profit items
24 are on toys, ice cream, films, cosmetics, and all
25 that sort of thing, which has nothing to do with the
26 filling of prescriptions except the pharmacist earns
27 income with which he can subsidize low priced prescrip-
28 tions.

29 MR. WHITE: Could I interject here one or
30 two questions, Mr. Chairman? The margin of sales



1 on Page 8 are shown at 33.2 per cent.

2 PROF. FULLER: Yes.

3 MR. WHITE: And the margins of prescriptions
4 is shown as 50 per cent on Page 32.

5 PROF. FULLER: On page what?

6 MR. WHITE: Page 32.

7 PROF. FULLER: Of my submission?

8 MR. WHITE: Yes. Gross margin on sales
9 is 50 per cent.

10 PROF. FULLER: Where did I say that?

11 MR. WHITE: You didn't say it. I computed
12 it.

13 PROF. FULLER: If you wish to look at it
14 that way --

15 MR. WHITE: Now then, prescriptions constitute
16 25 per cent of the total sales to the average retail
17 store. Would you be able to tell me the margin,
18 the gross margin on the sales of the 25 per cent --
19 the 26 per cent, rather -- of medicinal preparations --
20 would it be comparable to the margin on the prescribed
21 drugs?

22 PROF. FULLER: No. Let's put it this way:
23 the gross margin on proprietary medicines would range
24 anywhere depending on the nature of the product,
25 anywhere from 23 to 33 per cent gross margin. On
26 cosmetics it runs 32 to 33 per cent; on films, 32
27 to 33 per cent; on candy, about 22 to 23 per cent,
28 and on tobacco, magazines, and so on, about 15 per
29 cent. I don't know what it is on ice cream and toys.
30 It is the total sales of each department, multiplied by



1 that gross margin in the department, all that added
2 together, that gives a composite overall gross margin
3 of 32 to 33 per cent.

4 MR. WHITE: If the gross margin on total sales is
5 33.2 per cent, and if the gross margin on prescribed
6 drugs is 50 per cent, which I have taken from your
7 figures, then the gross margin on sales other than
8 prescribed drugs works out to 28 per cent.

9 PROF. FULLER: It is only an average. We
10 have them as low as 22 per cent.

11 MR. WHITE: I know it is an average.

12 PROF. FULLER: You are including ice cream,
13 candy and cosmetics --

14 MR. WHITE: I know it is an average. Now
15 then, glancing through this Canadian Pharmaceutical
16 Journal, I notice certain profit margins, and
17 here is one, 45 per cent. There is 25 per cent extra
18 profit on vitamins. Here is 46 per cent profit on
19 another item. I am inclined to think from looking
20 at these ads the margin of profit on medicinal prep-
21 arations other than prescribed drugs may be about the
22 same as the margin of profit on prescribed drugs.

23 PROF. FULLER: No, I wouldn't agree there
24 at all. I think you can identify those things by
25 looking -- I don't think I have a copy of it. Yes,
26 I have. I would like to look at them.

27 MR. WHITE: There are a number of ads in
28 there.

29 PROF. FULLER: Here is 25 per cent extra
30 costs on Mulcin. You only make a profit if you sell it.



1 You don't make a profit when you buy it and put it in
2 the cellar, and the thirty-three is actually what you
3 got.

4 MR. WHITE: I know, you have to have a good
5 profit margin. What I am trying to determine is the
6 profit margin -- you have 50 per cent profit margin on
7 a quarter of your sales. Now, can you not tell me
8 the profit margin on the 25 per cent of sales that
9 constitute medicinal preparations other than prescribed
10 drugs?

11 PROF. FULLER: I would say, as I have said,
12 somewhere between 23 and 33 per cent.

13 MR. WHITE: Well, using your figures in all
14 cases, if one excludes the gross sales of prescribed
15 drugs, and if one excludes the margin on gross sales
16 of prescribed drugs and calculates the margin on the
17 balance, the margin of sales is 28 per cent. I figured
18 this out. I am telling you.

19 PROF. FULLER: Yes.

20 MR. WHITE: Using your own figures.

21 PROF. FULLER: Yes.

22 MR. WHITE: Now then, if the margin on
23 sales of medicinal preparations other than prescribed
24 drugs is comparable to the margin of profit on pre-
25 scribed drugs, which I suspect it is judging from
26 these advertisements, then the margin of profit on other
27 products -- that is the 49 per cent balance-- is
28 16 per cent.

29 It has been said by you and by representatives
30



1 of the Pharmaceutical Association that such things
2 as ice cream and stationery and magazines and so on
3 are subsidizing the prescription department.
4 However, this would indicate that the reverse is the
5 case, the prescription department is subsidizing
6 the sale of these other products which constitute half
7 the volume of the drug store and which, of course,
8 by their very nature are being sold by variety stores,
9 chain stores and everybody under the sun. That is
10 a conclusion that is inescapable, I think, in looking
11 at your own figures.

12 PROF. FULLER: No, I won't agree with that
13 at all. What man in Canada has taken 42,000
14 prescriptions and analyzed them crosswise?

15 MR. WHITE: We haven't got the analysis.
16 That is another thing I would like to question you
17 about if it is all right with you, Mr. Chairman.
18 You put in here pharmacists' overhead. Would you be
19 charging all the pharmacy's manager's time into the
20 Pharmacy Department?

21 PROF. FULLER: As I said in my brief, very
22 few pharmacies keep departmentalized records over in
23 the United States or in Canada.

24 MR. WHITE: You arrived at that figure some
25 way. Did you charge all of his salary in there and
26 some ---

27 PROF. FULLER: All of his salary where?

28 MR. WHITE: When you compute it, the
29 pharmacist's overhead on page 32.
30



1 PROF. FULLER: Well, here in every instance
2 the proprietor's withdrawals are clearly part of
3 the operating expenses.

4 MR. WHITE: But I haven't made computations
5 from those figures.

6 PROF. FULLER: Pharmacists' salary. I would
7 like to point out again what I said yesterday about
8 38 per cent of the pharmacies in Ontario, something
9 over 40 per cent in Canada. This figure is total
10 income of \$15,000. That does not necessarily include
11 any one person. There are limited companies and
12 there are partnerships, and furthermore, about 70 per
13 cent of the pharmacists in Canada did not have an
14 average volume of business equal to this statistical
15 average or inventory.

16 MR. WHITE: There are poor businessmen in
17 every profession. We are talking about averages, as
18 we must. Now, the average works out to 26 per cent.
19 The number of people that are shareholders in the
20 business I do not think enters into it. I do not
21 think it makes any difference at all if there are one
22 or one thousand shareholders. They are making 26 per
23 cent after paying all their expenses ---

24 PROF. FULLER: They are making 26 per cent?

25 MR. WHITE: On their investment.

26 PROF. FULLER: That may be so.

27 MR. WHITE: Well, I have a number of other
28 questions.

29 MR. WREN: I don't think you answered Mr.
30



1 White's question.

2
3 PROF. FULLER: Perhaps I did not understand
4 the question.

5 MR. WREN: In your statistics, the
6 analysis and structure of your statistics, do you
7 charge the pharmacist's time wholly to the Pharmaceutical
8 Department, or is some of his salary time charged
9 to the sale of lawnmowers and garbage cans and so on?

10 PROF. FULLER: Some of his time should be.
11 As I have said, there is not statistical evidence --
12 I will wager a good hundred pharmacists in Canada
13 don't keep departmentalized records to know they are
14 not charging. They don't know.

15 MR. WREN: We are interested in determining
16 the cost of drugs in Ontario and the factors relating
17 to the cost of drugs. Now, his time is important
18 to us. His salaries and wages in a business concern
19 are large items. Now, in the structure of your
20 statistics, did you charge, and Mr. White asked you,
21 his time wholly to the drug department, or is some of
22 it spread out in the other activities?

23 PROF. FULLER: It is spread all the way
24 over. When I arrived at my \$1.10 overhead, as I
25 quoted in here, it was 56 cents to the pharmacist's
26 time whether it was a proprietor-pharmacist who filled
27 the prescription or an employee. That is how I
28 arrived at it.

29 MR. WHITE: Well, Professor, is this form
30 here the form sent to the retail druggists in compiling



1
2 the statistics?

3 PROF. FULLER: Yes.

4 MR. WHITE: Are these the only statistics
5 you had? Are these the only figures you had?

6 PROF. FULLER: Those are the only figures
7 I have had besides the prescription survey of 42,000,
8 and it is a similar questionnaire I believe to the one
9 that the DBS sends out to all organizations.

10 MR. WHITE: The point is this: Druggists
11 are telling us that the sale of sundries is subsidizing
12 the pharmaceutical department, but in this, I think
13 this indicates the pharmacy department is subsidizing
14 the sale of other products.

15 PROF. FULLER: I do not think you are
16 correct there in your figures at all.

17 MR. WHITE: The break-even figures that
18 you have given here are summary figures and none of
19 the raw figures are shown, so it is impossible to tell
20 what you mean when you say pharmacists' overhead.
21 How much have you got in there? Have you got heat,
22 or have you got rent covering the 20 square feet that
23 pharmacy actually occupies?

24 PROF. FULLER: You mean in the \$1.10?

25 MR. WHITE: I mean that a person can come
26 up ---

27 PROF. FULLER: If you flip back to the
28 earlier part of it, I arrived at it by this method:
29 There is 56 cents direct labour cost of the professional
30



1
2 services of a pharmacist when he is dispensing the
3 prescription, and there is 10 cents for the container
4 and 25 cents for all the other overhead of rent, heat,
5 light, depreciation, taxes, insurance, deliveries,
6 and so on, making a total of 91 cents. That was in
7 1957, and I feel it is now higher than the \$1.10.

8 MR. WHITE: Let's take the 56 figure.
9 Was that the total salary paid to the pharmacist
10 divided by the number of prescriptions issued?

11 PROF. FULLER: Pardon?

12 MR. WHITE: How did you get the 56 cents?

13 PROF. FULLER: It was based on, let us
14 say, about \$4.00 an hour for the pharmacist's
15 professional services. I believe Professor Geoffrey
16 of the Brooklyn College of Pharmacy at that time put
17 a stop-watch over a large area as to the length of time
18 it took to fill the average prescription, and therefore,
19 he got the pharmacist's time per minute, multiplied
20 by the time he filled the average prescription and
21 arrived at 56 cents by that method.

22 I simply used his method and applied it to
23 the Canadian scene and I think that 56 cents now is
24 too low for salaries have gone up.

25
26 (Page 661 follows
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28
29
30



1 MR. WHITE: Have you those figures available
2 from other sources?

3 PROF. FULLER: That is the only figure I have
4 from other sources. I think it stated in there if I
5 remember correctly where it came from -- am I not
6 right --

7 MR. WHITE: But if you take 56 cents, what
8 do you say the figures should be?

9 PROF. FULLER: For the salary alone?

10 MR. WHITE: Yes.

11 PROF. FULLER: I have not any idea, but I
12 do know that the average pharmacist's salary has gone
13 up since 1957. The pharmacist has to pay a graduate
14 anywhere from \$110 to \$125 a week now as against
15 \$85 to \$100 back in 1957. The wage cost for dispensing
16 prescriptions has gone up.

17 MR. WHITE: You say 56 cents and I say it
18 is higher.

19 PROF. FULLER: How much higher?

20 MR. WHITE: I don't know.

21 PROF. FULLER: You increase it according to
22 this figure here ---

23 MR. WHITE: The difference between 91 cents
24 and \$1.10, 19 cents.

25 PROF. FULLER: So this should be perhaps
26 66 cents.

27 MR. WHITE: If you take 66 cents times the
28 number of prescriptions filled by the average Ontario
29 druggist, it is going to work out to something over
30



1 \$5,000., while the manager pharmacist only gets
2 \$5600., so you are only charging \$600.00, approximately,
3 for all the time he spent selling all of his other
4 products.

5 What I am getting at is, I don't think
6 this analysis is correct.

7 PROF. FULLER: Why isn't it?

8 MR. WHITE: I think you over charge
9 the pharmacy department.

10 PROF. FULLER: You have taken 56 cents
11 times what, 7,651?

12 MR. WHITE: I am taking 66 cents as you
13 suggest.

14 PROF. FULLER: 66 cents times 7651?

15 MR. WHITE: Yes. I had not multiplied
16 it out but I will do so now. That works out to
17 \$5,049, or \$5,050, while the pharmacist manager -
18 and here I use the net profit figure - the proprietor's
19 salary is \$9,147. I say you charge the pharmacy
20 department too much.

21 PROF. FULLER: Let us put it this way:
22 Employees' wages are \$9,778. A pharmacist must be
23 on duty from 9 o'clock in the morning until 9 o'clock
24 at night, six days a week and part time on Sunday.

25 It is not evident to anybody the number of
26 prescriptions that manager fills as opposed to the
27 number of prescriptions his employee graduate fills,
28 but he must charge the cost price from the standpoint
29
30



1
2 of cost accounting, whether he is filling it or
3 whether a registered pharmacist is filling it.

4 MR. WHITE: Perhaps I should not say
5 you have allowed too much to the pharmacy department.
6 In the absence of supporting figures I could not
7 accept this very brief summary.

8 PROF. FULLER: You are privileged to
9 accept it or not accept it. You have said 7,651 times
10 66 cents. What figure did you get?

11 MR. WHITE: \$5,050.

12 PROF. FULLER: \$5,050 and here is the
13 total labour cost for the proprietor, of an average
14 of \$9,000. and the employees' salary, you say, is
15 \$5,000. 20 per cent of his total labour cost is
16 allocated then to the prescription department, whereas
17 23.2 per cent of his sales were in the prescription
18 department. Don't you think that would be rather
19 fair?

20 MR. WHITE: That is what I dispute.

21 PROF. FULLER: The law requires a pharmacist
22 to be on duty at all times when the drug store is
23 open, whether he is selling anything or not, and the
24 time must be charged to the prescription department.

25 MR. WREN: Mr. White contends those
26 statistics are not right, and last night in my hotel
27 room I was looking at the brief you submitted. I
28 felt you were using vertical plane rather than a
29 horizontal plane in assessing your labour and overhead.
30



1 PROF. FULLER: I don't quite get what you
2 mean, a vertical plane rather than a horizontal plane?

3 MR. WREN: Well, in the production -

4 PROF. FULLER: From the standpoint of
5 cost accounting this does not do anything. From the
6 standpoint of management this is called the "natural
7 classification of expenses" and it is only done on an
8 overall broad picture so that one manager can compare
9 his statements with another.

10 As far as cost accounting is concerned,
11 costs are incurred in the expense centres, and the
12 expense of running that centre must be applied to
13 what the cost of the prescription department is as
14 far as maintaining the pharmacy is concerned, rent, heat,
15 electricity, taxes, insurance, fixtures, and stock
16 in the dispensary and so on. When you get down
17 to functional classification, rather than natural
18 classification, you get something very different.

19 A study was made in the United States
20 costing \$175,000 over a five year period by Burley,
21 Fisher and Cox, an analysis of drug store costs and
22 profits which was published by McGraw Hill and
23 Company approximately 7 years ago.

24 Twelve stores were selected all over the
25 United States. When the store was opened in the
26 morning, an employee walked in and there was a man
27 behind him with a stop watch recording every single
28 movement, whatever he did, whatever he sold. It was
29 broken down by departments.

30 The rent, for instance, was allocated on this



1 basis. They drew lines on the floor of the store
2 dividing it into different areas. If a customer came
3 in the store, into department No. 1, and moved to
4 department No. 2, and eventually moved to department
5 No. 3, to buy tobacco, toothpaste, and so on, it was
6 all recorded. They indicated the number of customers
7 on a basis of 50-30-20 and they applied the rent on
8 that basis, 50 per cent to area 3, 30 per cent to area 2
9 and 20 per cent to area 1 and scored the different
10 departments into that area. By that technique and
11 with a stop watch, they counted every activity of the
12 professional and non-professional help.

13 They had special cash registers designed by
14 the National Cash Register Company for this scheme,
15 so that every sale was run up by departments. They
16 kept count of the prescription department, they called
17 it, but unfortunately, they did not keep a separate
18 count for prescriptions only. In their report if
19 someone came in and asked for "Pharmacist Jones
20 own private remedy for corn" that would be a sale in
21 the prescription department.

22 By allocating these costs according to
23 the costs that were incurred in each centre, they came up
24 with a standard for allocating costs to each department.
25 Therefore, if the high sum was 70 odd cents and the
26 low was below that, the limit for the 12 stores was
27 58 cents. I say 56 cents plus 25 per cent overhead,
28 so I am not out of line with that, which I consider to
29 be the best study ever made on the North American
30



1 Continent. I have criticized that study in print.

2 THE CHAIRMAN: I wonder if this would not
3 be a good time for us to have a five-minute break?

4 PROF. FULLER: Yes. Can I make just one
5 point?

6 If the immediate transaction cost was 58
7 cents and he sold a 50 cent bottle of his own cough
8 medicine -- or let us say a \$1 bottle of his own
9 cough medicine -- if you want to say the gross margin --
10 and I will take your figure for this.

11 MR. WHITE: I am using your figure, 56 cents.

12 PROF. FULLER: Not on cough medicine. It
13 would not be any more than 40. If his gross margin
14 is 50 per cent, and you take 28 cents, he is losing
15 8 cents, which means that he has not allocated the
16 cost to the Prescription Department. 56 cents for
17 labour therefore is not out of line, and \$1.10 is not
18 out of line with the only studies that have ever been
19 made.

20 MR. WHITE: You can do a lot of funny
21 things with statistics. If you take the average cost
22 of transacting and apply it to the smaller sales, it
23 will indicate you are losing money on the smaller
24 sales just as you do on your prescription.

25 For instance, maybe the average cost of a
26 transaction of drugs is 25 cents, you may say that
27 every time a man sells a package of chewing gum, he
28 loses 20 cents. It does not work that way. That is a
29 very fallacious comparison.
30



1 PROF. FULLER: I am not making a comparison
2 that way at all because in this study they had non-
3 professional help selling cigarettes and newspapers
4 and the pharmacist was not billed for that area.

5 We have whittled this down and abstracted it,
6 according to the pharmacist's professional duties and
7 what it cost to perform an average professional
8 transaction, not the cost of a pharmacist selling a
9 package of cigarettes.

10 MR. WHITE: To conclude this particular
11 part of the discussion, I think it is undeniable that
12 the margin on drugs is far higher than the other
13 products sold in the store. Secondly, using your
14 figures, the more prescriptions filled, the higher
15 the income both in sales and as a percentage of the
16 total.

17 So if those points are true as taken from
18 your figures, then the Pharmacy Department is sub-
19 sidizing the rest of the store.

20 PROF. FULLER: No, that is not true at all
21 and I did not say and I have not shown that the higher
22 the number of prescriptions filled the higher the
23 total income. I said exactly the reverse. On page 28
24 the table clearly reveals and one cannot say your
25 statement is true. It is clearly shown that the
26 number of prescriptions have no relation to the dollar
27 value.

28 MR. WHITE: "It is clearly evident from
29 "this table that in pharmacies with
30



1 "approximately the same total sales, the
2 "total income is highest in the pharmacies
3 "that fill the most prescriptions."

4 THE CHAIRMAN: What are you reading from?

5 MR. WHITE: The first paragraph on page 28.

6 THE CHAIRMAN: What is that?
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25 --- (Page 671 follows.)
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1 PROF. FULLER: In Canada, and 41 per cent,
2 and there is a vast difference, Mr. White, I am
3 sorry to have to disagree, there is a vast difference
4 between the word "higher", and the superlative,
5 "highest".

6 MR. WHITE: I will use higher if you wish.

7 THE CHAIRMAN: Gentlemen I think this is
8 a good time to recess.

9 ---Recess

10 THE CHAIRMAN: Gentlemen I think I should
11 state at this time that it is not the Committee's
12 intention to sit this afternoon. Whether or not we
13 conclude all of the cross-examination, or questioning
14 of Professor Fuller today, I wouldn't know, but if
15 we do not finish it would be deferred for some several
16 weeks to a time which would certainly meet your
17 convenience Professor Fuller.

18 PROF. FULLER: Thank you.

19 THE CHAIRMAN: We appreciate that this
20 matter of statistics is a very difficult one, and we
21 are simply trying to get at the information which
22 bears on this Committee's subject matter. Mr. Rice?
23 It follows then that we would have about an hour
24 remaining this morning.

25 MR. RICE: Professor Fuller to get back to
26 your statistics here in Ontario here, 511 pharmacies
27 reporting, I believe that you agreed with me before
28 that on this figure it would appear that the income
29 from an investment point of view would be around 25
30 per cent, or 20 per cent regardless of who it went to?



1 As you pointed out in your other questions it may go
2 to several people; may go to a limited company, may
3 go somewhere else.

4 PROF. FULLER: Yes. . Having used a calculating
5 machine for several years, I am very allergic to
6 mental arithmetic. If you say that is what it comes to
7 I will agree with you. I will put it on a machine when
8 I get back to my office.

9 MR. RICE: Then we have taken into consider-
10 ation the investment of the pharmacist, \$21,880, and
11 to take your figure of the total income which he
12 received from that investment, \$15,164 you get a very
13 large per cent, somewhere close to or just under 70
14 per cent from a business point of view.

15 PROF. FULLER: I disagree. \$9,147 is a
16 proprietor's salary. He can earn that working anywhere,
17 if he didn't work for himself. That is not correct
18 at all to say that is a profit return on the investment.

19 You must take proprietor's salary entirely
20 out of your figures in calculating your return on
21 the investment. He gets that \$9,147 for the function
22 of working, just like any other employee and manage-
23 ment, and the only figure that you can use in calculating
24 the return on his investment is the \$5,678 plus
25 39, and that is not 25 per cent.

26 MR. RICE: Then if you are going to consider
27 his business from a purely investment point of view
28 does that not have to be compared to other investments,
29 like mortgages and house renting and so on.

30 PROF. FULLER: That is not comparable in the



1 money market, that is on business risks at all. If
2 you were going to buy a business as a going concern,
3 almost any retail organization -- they are not my
4 figures. It is things that the people have lived
5 by for decades in the Western hemisphere. You expect
6 to get all of your capital back within four or five
7 years.

8 I mean the situation might change. Might
9 put a new road in and destroy your business and
10 you do not expect simply the 6 per cent difference
11 in mortgages, if that is all you want.

12 MR. RICE: Well the \$9,147 is the salary.
13 How much of his time would be spent actually on dis-
14 pensing drugs?

15 PROF. FULLER: That is very difficult to
16 say because we would have to know what proportion
17 of the 7,651 prescriptions on the average that were
18 dispensed in the average pharmacy in Ontario,
19 how many the proprietor filled himself and how many
20 his employees filled.

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27 Page 676 follows.
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1 MR. RICE: Are there any druggists in
2 Ontario that operate and dispense drugs without these
3 other departments?

4 PROF. FULLER: Oh, there are several in
5 Toronto. I can think of Starkman's, Milton up on
6 Eglinton Avenue and Mel Osborne up at the corner of
7 St. George and Bloor who has some other things
8 but not the general run.

9 MR. RICE: In your survey did you get returns
10 from many stores of that nature?

11 PROF. FULLER: None from Ontario, no.

12 THE CHAIRMAN: Well, at least on the face
13 of it these outlets that you mention appear to be
14 continuing in business on a satisfactory level.

15 PROF. FULLER: Oh, I think so.

16 THE CHAIRMAN: You put it in that sphere
17 with that use of words?

18 PROF. FULLER: Yes.

19 THE CHAIRMAN: And they do not have the benefit
20 of any assistance from any other non-drug items?

21 PROF. FULLER: Yes and no. I think you will
22 find that Starkman's have quite a business in surgical
23 instruments and sick room supplies, crutches and wheel-
24 chairs and many supplies that a doctor uses. It is
25 not all just dispensing. Mr. Osborne has a small
26 department where you can buy magazines and tobacco.

27 MR. RICE: Do many of the prescriptions
28 come from the manufacturer in the form in which they
29 are prescribed?

30 PROF. FULLER: You mean they are tailor made



1 in the factory and the pharmacist dispenses them exactly
2 as they come from the package?

3 MR. RICE: Yes?

4 PROF. FULLER: He simply puts them in
5 another container.

6 MR. RICE: So that the actual mechanics
7 of dispensing in a great many cases is taking a
8 number of pills from a big bottle and putting them
9 in a little bottle?

10 PROF. FULLER: Well, that has been said
11 many times quite truly. I think I know what is in your
12 mind. The law says that no one other than a
13 pharmacist shall do that. It does seem rather an
14 expense to have a high priced pharmacist perform
15 such a simple mechanical function. There was a case
16 in the last two or three years in a chain store where
17 a non-professional filled a prescription. The firm
18 was brought into Court, the Supreme Court decided
19 to the effect that the fact that these little white
20 tablets could have been bought over the counter if
21 they had not been a prescription was beside the point.
22 The law is clear that no one but the pharmacist can
23 dispense a prescription. I think if anyone thinks
24 that someone else can then just go into a pharmacy
25 and see all those thousands and thousands of little
26 white tablets. As Dean Hughes pointed out in his
27 original brief sometimes there is only the difference
28 of one letter in a name but if you make a mistake on
29 that one letter you do not want to be faced with it.
30 It takes four years to train a pharmacist and society



1 has built that up.

2 THE CHAIRMAN: I think it should be noted
3 at this time that hospital dispensaries do not require
4 a registered pharmacist.

5 PROF. FULLER: In Ontario they do not but
6 in Saskatchewan they do. If you want to get into the
7 subject of hospitals, I hope you will not think me
8 too presumptuous, but I would suggest that you might
9 in your investigation investigate the cost of drugs
10 in a hospital that do employ pharmacists who act as
11 a purchasing agent or has some control or voice in
12 the purchasing versus other hospitals where non-pharma-
13 cists perform that function. I think that would be
14 an objective way of getting at some of your problems.
15 Of course, it may not lead to anything. A scientist
16 follows a path to see where it will lead, he does not
17 have preconceived ideas and then go out and do some-
18 thing on what he has preconceived before. I do
19 feel that you would discover some interesting facts
20 if your committee did that. My personal opinion
21 is for the safety of the public there should be a
22 pharmacist in every hospital of 50 beds or more in
23 Ontario.

24 It seems quite strange, anomolous perhaps
25 might be a better word, that a nurse can dispense
26 a prescription in a hospital and it is perfectly
27 safe but she cannot dispense a prescription in a
28 pharmacy. I think the public is entitled to the
29 same protection in a hospital as they get outside
30 when they are confined to hospital.



1 MR. RICE: Could you help the Committee at
2 all as to what percentage of prescriptions require
3 the pharmacist to compound?

4 PROF. FULLER: Well right now, I would say
5 it was very low, perhaps not over 5 per cent or 6
6 per cent. Then again, I think we get all mixed up
7 when we start talking about a provision on the terms
8 of gross profit. We should talk about a provision
9 in terms of the service rendered to the community.
10 If the community wishes to have a pharmacist on hand
11 for emergencies then they must pay for the stand-by
12 the same as you have a fireman when there is no
13 fire in the community. In this survey 55.5 per cent
14 of the pharmacists are in cities below 50,000. There
15 are thousands of them in communities in the west under
16 500 and under 1,000 population. It is obvious the
17 pharmacist cannot earn a living as a pharmacist alone,
18 he must sell all these other things or he could not
19 possibly exist. He must be there, he must be trained
20 for any emergency that a doctor writes the prescription
21 for. Sometimes it may be an obsolete type of
22 prescription, say bichloride of mercury one in
23 five thousand with a base of aniline and white
24 petrolatum to make one gram. If the pharmacist makes
25 an error, made that one in one thousand instead of
26 one in five thousand, as the case may be, the patient's
27 eyes would be in great danger. That is one of the
28 legal responsibilities of the pharmacist in performing
29 that activity. Can he recover his transaction cost
30



1 and some sort of a professional fee for the responsi-
2 bility by even a 99 per cent mark-up on the cost of
3 bichloride of mercury which might amount to about one-
4 tenth of a cent and the base which might be one cent
5 and the container which may be ten cents? It cannot
6 be done on a gross margin basis at all. The community
7 must have him in the community, a man who is trained
8 and able to do these things when the doctor asks him
9 to do it in the practice of his medical profession.

10 MR. RICE: I take it from your answer that a
11 pharmacist in his business does not spend all his
12 time dispensing drugs.

13 PROF. FULLER: No, he does not.

14 MR. RICE: And your statistics for Ontario,
15 23.2%, would that represent a fair representation of
16 the time that a pharmacist will take dispensing drugs?

17 PROF. FULLER: Well, I have been a very
18 severe critic throughout the years of that method of
19 reasoning for cost accounting and I cannot change my
20 method of reasoning now. The dollar value of prescrip-
21 tion rates is \$24,000 here in comparison with \$105,000,
22 roughly 25 per cent of the cost. As every cost accountant
23 knows, that is a fallacious way of saying that
24

25 25 per cent of the cost should be allocated to
26 the Prescription Department. That 23.2 per cent is
27 made on that basis. This is a ratio of the total sales
28 of \$24,000 to the \$105,000 and we cannot allocate
29 the expense of the Prescription Department on that basis
30 at all. The fact is the average number of prescriptions



1 was 7,651 that the pharmacist filled in a year's time.
2 If you are willing to pay for that service, what is
3 its value to the community?

4 MR. RICE: I was wondering if you could
5 say whether or not it would lower the cost of drugs
6 if you had fewer pharmacists confined to fewer stores?
7 In that way you could let the other stores handle these
8 other items and not dispense drugs?

9 PROF. FULLER: I would like to answer that
10 question yes and I would like to answer that question
11 no. Put it this way: take the case of a barber shop
12 where it opens at nine o'clock in the morning and there
13 are six barbers there and the people keep coming in
14 all day long keeping the six barbers busy right up
15 until seven o'clock. In that case people think that
16 a haircut should be cheaper but we know the fact of
17 the matter is that there is a lot of wasted time, that
18 sometimes three barbers are sitting around doing
19 nothing.
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24 (Page 683 follows)
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2 Now, if you move that into a pharmacy, the
3 pharmacist is busy all the time practising or operating
4 at his highest skill. But remember, he must be paid
5 as a pharmacist, as a professional person. Therefore,
6 the cost immediately starts to rise there, whereas
7 in the ordinary one, where roughly 25 per cent of his
8 time, -- if we can accept that 25 per cent of his
9 time; not the dollar value -- goes into the
10 dispensary, then in this survey in the United States
11 they took 25 per cent of his professional salary and
12 allocated it, and they charged the professional salary
13 to the soda fountain the same was as they did in the
14 prescription department.

15 That is one reason why I think it was too
16 low. There, you see, he is earning by-income to
17 support this other thing.

18 MR. RICE: Take the example of a pharmacy
19 that has a soda fountain and sandwiches. Is there any
20 relation between the mark-up that the pharmacists make
21 on sandwiches and the relation of the mark-up he
22 would make on drugs?

23 PROF. FULLER: I am sorry. In 34 years
24 of teaching pharmacy management I have refused to have
25 anything to do with the management of a soda fountain
26 or lunch counter in pharmacies, and I have stuck with
27 it successfully for between 33 and 34 years.

28 You can go down to New York and see a drug
29 store with a seating capacity of 674. I am not interested
30



1
2 in teaching pharmacists how to run a restaurant. I
3 have absolutely no knowledge of the economics of a
4 restaurant or an ice-cream parlour. I assume they
5 make money out of it; otherwise they wouldn't have it
6 in their stores.

7 MR. RICE: We hear some pharmacists say
8 we have a professional man dispensing coffee and
9 doughnuts.

10 PROF. FULLER: What is that?

11 MR. RICE: Receiving a professional salary
12 and dispensing coffee.

13 PROF. FULLER: Yes, the reason being it
14 is not possible for him to earn sufficient living
15 unless he does.

16 If we take these 165 Ontario pharmacies
17 here, the average receipt from prescriptions was
18 \$24,613. If we take a gross margin of 50 per cent,
19 then all he gets out of this is \$12,306.50 on which
20 to operate the business, get a salary for himself and
21 to pay another man. It simply could not be done.
22 He simply has to go out -- his economics are vital
23 that he must sell all these other things in order to
24 maintain this prescription department.

25 MR. RICE: If he doesn't make anymore
26 money on his coffee than his competitor makes on his
27 coffee, and yet he is receiving a professional salary,
28 his cost of drugs would have to be that much more to
29 compensate the difference of salary.
30



1
2 PROF. FULLER: I think the pharmacist's
3 salary should be the differential what he can hire
4 somebody to run the lunch counter and serve the coffee,
5 if you will, and what he would have to pay him, and
6 what he should receive as a professional person working
7 for somebody else.

8 That differential, during the time he is
9 serving coffee, should be charged to the prescription
10 department and I stake my life on that. That is very,
11 very, sound cost accounting.

12 MR. RICE: Can we move into the other
13 factor that enters into the cost of prescriptions;
14 that is, the overhead. Taken into this is rent and
15 salaries and so on, advertising, electricity, telephone,
16 et cetera? Is that correct? All these are part
17 of the overhead, and in this question of overhead,
18 the pharmacist again would have some control over his
19 overhead in the selection of where he locates his
20 pharmacy, how long he keeps his lights on, how
21 expensive is his advertising, and so on.

22 PROF. FULLER: I think that is the total
23 accounting of management that you have control over
24 your own activities, and take the consequences; if
25 you make the right decisions, you are all right, and
26 if you don't, you take a loss.

27 MR. RICE: In the end result then, a
28 pharmacist, by his management of this overhead can
29 affect the cost then that he is going to have to charge
30



1
2 for his drugs?

3 PROF. FULLER: If he is a good manager
4 or poor manager, that is quite true, yes. The same
5 thing in any other business. There are poor business
6 men and good business men.

7 MR. RICE: So that the difference in the
8 overhead is going to have an effect on his particular
9 cost of prescriptions that he is going to charge the
10 customer coming in?

11 PROF. FULLER: I wouldn't like to state
12 it that clearly because, gentlemen, I think you must
13 realize that in no College of Pharmacy in North
14 America that I am aware of is cost accounting taught
15 to pharmacists, and it is just an overall picture that
16 he uses these figures here. He uses similar figures
17 in the United States. The average is 33, 34 per cent
18 gross margin, and if his expenses are generally on the
19 whole operation, total operation, about 28 to 30
20 per cent, he feels he is doing all right, and he doesn't
21 know any more about it than that pricewise.

22 MR. RICE: The reason, Professor, we are
23 asking these question is that it would appear when
24 you purchase a prescription at one retail drug store
25 you can get it at a different price if you shop around
26 and buy it at another one.

27 I was wondering how these factors that you
28 set out here would enter into that. That is why I
29 picked on the price of overhead. Maybe one man can
30 manage his store that much better, and he can sell his



1
2 prescriptions at a loss.

3 PROF. FULLER: I hope you will not
4 presume me to be presumptuous when I say I very much
5 dislike that kind of a question for this reason, that
6 you can take a prescription and you can go around to
7 different drug stores and you will get a variation
8 of prices. This proves beyond a question of doubt
9 that they do not follow the blue chart at all.

10 Secondly, you must remember some of them are
11 good business men and some of them are poor business
12 men. If there is a variation in price, as there
13 should be, and as there is in many other things,
14 and I think we can get in our cars right now and in
15 15 minutes be in a grocery store where I can buy a
16 ham for \$1.59 and go to another one one hundred yards
17 away and pay \$1.69, but I don't ask the government
18 to investigate that situation. It is just the natural
19 every-day course of business.

20 You get business deals on an automobile
21 where the differences are hundreds of dollars. I
22 turned in my car last spring and they offered me
23 \$700.00 for it, where one offered me \$1,400.00 but
24 there was a catch attached to it, I had to buy some-
25 thing I didn't want.

26 I think there will always be a difference
27 in price and I am glad to see it because it proves
28 there is competition.

29 THE CHAIRMAN: I think you must understand
30



1
2 the reason this Committee was appointed was because
3 of the great public interest in this subject, and that
4 very question that Mr. Rice put to you has been put
5 to each member of this Committee by his constituents,
6 and in our examination, we have to --

7 PROF. FULLER: Oh yes, I am not blaming
8 you at all.

9 THE CHAIRMAN: I think it is a very proper
10 question, and I think your answer was a correct answer
11 too.

12 PROF. FULLER: That is fine, but you see
13 how difficult it is for an economist to answer something
14 in the field of pharmacy which is common practice in
15 every type of business.

16 THE CHAIRMAN: I don't think the question
17 is unfair.

18 PROF. FULLER: I didn't say "unfair". I
19 don't think I used that word. I think I said I
20 disliked it, and I will ask you to desist, and remove
21 the word from the record. I am very happy to answer
22 it for you.

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24 (Page 690 follows)
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1 MR. RICE: In calculating your example on
2 page 32 of your brief for the pharmacist's overhead,
3 did you take all the factors into consideration like
4 advertising and telephones and electricity and so on?

5 PROF. FULLER: Yes, those things added to-
6 gether give the sum total of the overhead in each
7 prescription calculated at 25 cents.

8 MR. RICE: Reading the brief, you have
9 calculated it at \$1.10.

10 PROF. FULLER: That \$1.10 was made up of
11 a direct labour cost plus 25 per cent overhead plus
12 a 10 cent labour cost.

13 MR. RICE: Would the advertising of pharmacists
14 relate more to the other articles he is carrying than
15 to drugs?

16 PROF. FULLER: It is considered fairly
17 bad ethics by the pharmacy profession to advertise
18 prescriptions. Starkman's and Milton and others
19 advertise, institutional advertising, but they don't
20 advertise prescriptions at prices directly, and there-
21 fore as far as the run of the mill pharmacy, the
22 corner pharmacy, is concerned, where does he spend his
23 money on advertising?

24 Perhaps in a little local newspaper or
25 house organ that goes around the area. Perhaps he
26 gives rulers away or includes the expense of dressing
27 his windows, and that may be charged to advertising.

28 If he is a member of I.D.A., he pays so
29 much a month towards the advertisements in the
30



1 Toronto and other newspapers.

2 If you look at those newspapers you will
3 find very little mention made of prescriptions. If
4 there is a little corner and you want to isolate it,
5 perhaps the pharmacist pays \$4 a month towards it,
6 this little section may be allocated to the pre-
7 scription department of an insignificant amount,
8 amounting to 10 per cent or less.

9 MR. RICE: Did you take those things into
10 consideration when you were calculating your overhead?

11 PROF. FULLER: That is what meant by this
12 25 cents. As I say, this 25 cents was set forth in
13 1957, and overhead has increased since then, and
14 that ought to be increased slightly, too.

15 MR. RICE: So that under the heading
16 "Overhead", the pharmacist has some control over his
17 overhead and therefore can control the end price of
18 his prescription to some extent.

19 PROF FULLER: He can control it only in the
20 sense that if a businessman makes the most of his
21 own business, he has control over it.

22 He can spend his money wisely or unwisely.
23 He can spend too much on advertising and not get
24 results commensurate with the amount, and when he does
25 he has been unwise. He can control it in that sense.

26 MR. RICE: The other factor that enters into
27 the cost of prescription is the cost of ingredients.
28 Has the pharmacist some control over those costs by
29 selecting manufacturers and so on?
30



1 PROF. FULLER: I would say in the majority of
2 cases the pharmacist has no control over the cost of
3 the ingredients he must dispense. He must dispense
4 what the doctor orders. If he orders a specific product,
5 and a great of many of them are prescribed by what
6 some call "brand names" today, the law requires them
7 to dispense that and nothing else. He is liable to
8 the law and he must do that.

9 MR. WHITE: If the generic name is prescribed,
10 is he still morally obliged to supply the cheapest
11 generic drug possible, or should he supply the most
12 expensive at his own discretion?

13 PROF. FULLER: I think that is a rather
14 pithy question. You ask, "Is he morally obliged?".
15 My own study of philosophy is I do not think there are
16 any legal compulsions that make you act morally in a
17 given situation.

18 MR. WHITE: Do the ethics of a profession
19 require him to supply the cheapest generic drug he
20 has available?

21 PROF. FULLER: There is no such statement
22 anyplace in pharmaceutical ethics of that nature.

23 If I were a practising pharmacist again,
24 I would feel if this prescription were being dispensed
25 for someone who might be a member of my own family,
26 I would want the very best for my own family regardless
27 of the price. It is not a case of whether it is a
28 generic or brand name, it is a case of what is best
29 from the standpoint of pharmacology.
30



1 MR. WHITE: This is very important, because
2 the medical profession at the moment seems to be
3 turned more towards the use of generic names in the
4 hope that it will lower the cost of the drug to the
5 patient.

6 If the druggist is not providing it by
7 generic name at the least expense for that prescription,
8 and if in fact he is supplying the most expensive,
9 it is obviously thwarting the intention of the doctor.

10 I am wondering if the profession should not
11 make a rule of thumb to supply the least expensive
12 generic drug.

13 PROF. FULLER: I cannot answer your question.
14 I have no knowledge of what the pharmacist does when
15 he gets a prescription written in generic terms.

16 I have no knowledge and I have not watched
17 for this. I do know that this is such a knotty
18 problem I feel very deeply for you gentlemen because the
19 people of the Province of Ontario have put almost an
20 intolerable burden on your shoulders to discover
21 something that is, to my way of thinking as a
22 professional person a downright myth. You can go
23 out and buy acetylsalicylic acid tablets. You must not
24 call them "aspirin" in Canada unless it is Bayer, a
25 trade name. This is the only country that has that
26 privilege. You can put one brand in a glass of water
27 here, and another here, and you can stand there and
28 watch for 24 hours, if you want to. You can come back
29 tomorrow morning and in certain brands you will find
30



1 in the bottom of the glass it has not disintegrated
2 one bit. You can throw it at the wall and it won't
3 even break.

4 The generic name for that is acetylsalicylic
5 acid and some are cheaper than others. It is 90 cents
6 for a hundred in one case. If you want this pre-
7 scribed -- and I am using this as an illustration
8 simply because it is cheaper -- they both have five
9 grains of acetylsalicylic acid, but a chemical
10 analysis would reveal this, the method by which
11 it is made shows that citric acid and sodium bicarbo-
12 nate are put in, and when it is added with water, a
13 chemical reaction takes place to produce certain results.

14 According to the advertising it is going to
15 be absorbed faster and you are going to get relief
16 faster.

17 We have a whole group of new tablets called
18 "delayed action tablets" where you take a medicinal
19 and put a certain coating on it, and another one on
20 that, and another one on that. The timing device is
21 arranged so that each part of it will be dissolved at
22 a time and you get a delayed action several times, so
23 that you only need to take one tablet.

24 MR. WHITE: I want to establish one point.
25 Would it be fair to say that if a physician prescribes
26 a generic drug, the individual druggist at his
27 discretion can dispense either an inexpensive or a
28 very expensive drug and the profession does not seek
29 to influence the individual druggist in that matter.
30



1 Is that right?

2 PROF. FULLER: I do not know. I am sorry,
3 I feel I am a bad boy suddenly.

4 THE CHAIRMAN: There is nothing personal in
5 this.

6 PROF. FULLER: You are asking a question that
7 to my way of thinking is quite obvious and anybody
8 can answer it.

9 MR. WHITE: Give me an obvious answer then.

10 PROF. FULLER: I do not know the answer any
11 more than you know it. It is quite obvious there is
12 nothing in the law that says he has to dispense the
13 most expensive or the least expensive one.

14 MR. WHITE: What did you teach your students?

15 PROF. FULLER: I did not teach them dis-
16 pensing, I teach management.

17 MR. WHITE: You do not know?

18 PROF. FULLER: I do not know what the
19 pharmacist would do in that situation. I would go back
20 to my pharmacology and choose the one that in my
21 knowledge would do the best work.

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23
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27 --- (Page 698 follows.)
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1 PROF. FULLER: It might be the cheapest,
2 and might be the most expensive. If it is the most
3 expensive one time, the cheapest the next time, all
4 right. That is what I do. I can only speak for myself.

5 MR. FULLERTON: It has been mentioned that
6 some pharmacists pay a commission to doctors for
7 prescriptions. Are you aware of this, Prof. Fuller?

8 PROF. FULLER: I don't think that is true.
9 It may exist in isolated cases but I am quite certain
10 that it isn't true to any general extent.

11 MR. WREN: Your College of Pharmacy, how
12 would they deal with a pharmacist --

13 PROF. FULLER: I don't know as they have
14 any authority in law to deal with it. If they knew
15 about it, the Discipline Committee would likely call
16 the individual in and at least severely reprimand him
17 and try to persuade him it was in the best interests
18 of everybody involved not to.

19 That is a relatively small segment of our
20 economy. We have other segments where you get a
21 group of doctors who set up a clinic and buy a
22 building and then they want a pharmacist in the
23 building and they rent him a space for a dispensary,
24 and this happened, they come to me for consultation
25 as to whether they should take the location or not.

26 I know one place in Ontario within the last
27 two years where this group of doctors wanted 25 per cent
28 of the total sales as rent. When a pharmacist only
29 makes a net profit of 5 per cent how on earth
30



1 can he enter into that situation?

2 In the City of Saskatoon the doctors are now
3 building, at this time, a big building as a clinic and
4 they own it, the limited company, and they felt that
5 they did not have enough information as to the rent,
6 and the secretary-treasurer of the organization wrote
7 me and asked my advice, and I couched it in the most
8 polite language possible. Some of the people involved
9 wanted it on a percentage of sales basis and I tried
10 to point out politely that that amounts to an unseen
11 -- not a kick-back, I didn't use that term, but he
12 really is taking some of the profit as the owner of
13 the pharmacy and I thought the only fair way was to
14 rent it on a square foot basis on the same basis as
15 they rent it, square foot, to the doctors in the build-
16 ing and I asked him if he would write me back and tell
17 me eventually what they did and he took the time to
18 write back and said what they are doing is renting it
19 on a square foot basis. I know other problems.

20 THE CHAIRMAN: That takes us into what might
21 be described as a grey area?

22 PROF. FULLER: Yes.

23 THE CHAIRMAN: I think the principle of
24 renting space for retail stores and basing it on a
25 percentage of gross, which varies according to the
26 type of business you are in, is a well-established one.

27 PROF. FULLER: In the plaza shopping centres,
28 that is right, but to apply that to a medical centre
29 where the people who are writing the prescriptions own
30



1 the building, they become unseen partners in the
2 pharmacy then.

3 MR. RICE: Prof. Fuller, dealing with what
4 Mr. White said to you before about generic names, I
5 note in your brief you set out that there is very little
6 difference between a generic name and a trade name with
7 regard to dispensing the drug, but Mr. Macdonald yester-
8 day testified that he preferred to write his prescrip-
9 tions with the generic name, and if you did so would the
10 pharmacist then have some control over the cost of the
11 prescription by his selection as to what way he would
12 compound it or make up the prescription?

13 PROF. FULLER: That is what I tried to do
14 I believe in about the second to last page, in page 32
15 of my submission here. If it cost the pharmacist \$1.10
16 overhead and he desires 39 cents profit on his invest-
17 ment of this \$21,000 that you have mentioned, and the
18 cost of the ingredient is now \$1.50 for the brand name --
19 let us say that some people who have gotten a lot of
20 newspaper publicity, they said they could reduce the
21 cost of medicine, cut it in half if this particular
22 generic named product were used, let us say, and that
23 is not an argument that is true. It came down to
24 75 cents, your differential is only 75 cents, isn't it?
25 It isn't half of the total cost of the prescription
26 because the pharmacist must get his \$1.10 plus his 39
27 cents profit.

28 MR. RICE: I fully appreciate that, Prof.
29 Fuller. I was just wondering -- it would have an
30 effect, some effect --



1 PROF. FULLER: That is, to my way of
2 thinking, the effect it would have. That is the
3 only effect it could have.

4 MR. RICE: And I believe Dr. Macdonald also
5 said, am I correct here, aspirin tablets if he ordered
6 under the name acetylsalicylic acid that it would be
7 much cheaper than if he ordered it by the trade name
8 aspirin so therefore he used to always order it by the
9 cheaper name.

10 PROF. FULLER: That is a very peculiar example,
11 peculiar only to Canada. Canada is the only country
12 in the Western World that gave the sole right to the
13 use of the word aspirin to the Bayer Company after
14 World War I. Every other country in the world they
15 lost in. There is a Squibbs Aspirin, a St. Joseph's
16 Aspirin and all kinds of aspirin in the United States
17 and every other country. In Canada one must not say
18 aspirin unless you mean Bayer so that is a rather
19 peculiar illustration that the doctor used.

20 As far as any doctor is concerned, I think
21 you can all read this, there is a convention of
22 high class medical men, one gets up and gives a
23 paper on the digestion on facts, or the facts in the
24 diet causing hardening of the artery, and in heart
25 disease, and the next man gets up and disagrees
26 point blank and proceeds to give just the opposite.
27 I wouldn't like to contend that any doctor, either on
28 an economic or medical basis -- you get difference of
29 opinion there, and Dr. Macdonald, no doubt, has his
30



1 ideas and no doubt I have mine. He has the right to
2 speak on medicine. I have the right to speak on the
3 economic side of it.

4 MR. RICE: Now, Prof. Fuller, taking into
5 consideration the pharmacist's control over these
6 three items, that is, he has some control over the
7 cost of ingredients, provided it is ordered in generic
8 name; he has some control over his overhead, and he
9 has absolute control over how much profit he wants to
10 make. Would that provide an explanation for the wide
11 spread in prices?

12 PROF. FULLER: Yes, I would say that that
13 perhaps was a rational approach to it although we can
14 go out and find a doctor that would charge \$15 for
15 taking my tonsils out and find another doctor who
16 wants \$25 and another one who wants \$50 although the
17 doctor in a certain clinic in New Haven back fifteen
18 years ago said that I had had them out though I don't
19 remember.

20 MR. RICE: In Ontario here could you give
21 the Committee any idea of how wide that spread would
22 be in an average prescription?

23 PROF. FULLER: No. I have no knowledge.
24 There have been sporadic attempts at interest in this,
25 people who have taken a prescription and run around
26 to half a dozen stores to try and make a story out of
27 it, and that is the only knowledge that I have.

28 I have never attempted to do that myself or
29 to go into a pharmacy and spot a certain type of
30



1 prescription and then go into their pharmacy and finger
2 through their prescription files and see if I can find
3 the exact prescription and see what they charge, see
4 if there is any differential.

5 MR. RICE: You couldn't help the Committee
6 whether it is 50%, 100%?

7 PROF. FULLER: No. I would have no idea.
8 I think the idea there is a wide differential among
9 pharmacists is very much exaggerated, terribly
10 exaggerated.

11 MR. RICE: Then you mentioned before that
12 pharmacists, on the matter of drugs do not advertise
13 their preparation or their pharmaceutical aspect of
14 their business. If there is a wide spread how could
15 a member of the public take advantage of this wide
16 spread by shopping?

17 PROF. FULLER: I am afraid I can't quite see
18 what you are getting at, any further than I have
19 discovered by observation that I can buy a certain
20 can of ham in one grocery store for \$1.59 and the same
21 thing is \$1.69 in another. As a rule, people do not
22 take a prescription into a pharmacist and say "How much
23 is this going to cost me?" and run around to the next
24 pharmacy and say "How much is this going to cost me?",
25 and another one. That has been done, but the number of
26 people who do that I would claim -- a very wild guess --
27 amounted to perhaps one-tenth of one per cent of the
28 people.

29 We try to build the idea in the pharmacy
30



1 at the Faculty of Pharmacy to train the people to
2 select their pharmacy as they would select their
3 physician and the pharmacist is a member of the
4 community. He is on call at all times, day and night,
5 Sundays and holidays, and so on and get to know the
6 people in the community and treat them fairly, and that
7 is about the only way the pharmacist can advertise the
8 professional aspects of his organization.
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28 --- (Page 706 follows.)
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1 THE CHAIRMAN: It also follows that it is the
2 inherent right of anybody in a community to change
3 lawyers or doctors or drugstores?
4

5 PROF. FULLER: Oh, sure.

6 MR. RICE: I was trying to look at the problem
7 from the point of view of the ordinary man on the
8 street who has a prescription to fill. He wants to
9 have it filled with quality products at an economic
10 price. Is there any way he would know of or could
11 ferret out a store that could fill his prescription
12 at a economic price or where he could get the best
13 price to fill his prescription?

14 PROF. FULLER: I can tell you that if he
15 wants to spend \$146 to fly by Viscount to Winnipeg
16 he could go in and get the prescription filled for
17 \$1 plus the price of the ingredients. However, it
18 will cost him \$146 to fly there but that is the only
19 situation that I know of in Canada where you can
20 shop around.

21 MR. RICE: You would not suggest that instead
22 of going into a pharmacist in Rosedale that he
23 go downtown to a department store where he could get
24 it cheaper?

25 PROF. FULLER: There may be a five per cent
26 or ten per cent differential but -- I am a little
27 bit embarrassed because I feel when you are talking
28 to students, a captive audience you get carried
29 right along but I am afraid that I have forgotten
30 that you are members of the legislature and perhaps I



1 should not be saying some of the things in the way
2 I am saying them. If I am saying that wrongly I hope
3 you will pardon me. If a man phones Malton Airport
4 and says that at such and such a time there will be
5 a bomb on flight 315 or a person goes into a police
6 station and says he has committed a crime and they
7 find out it is not true but just mischief, we have
8 laws to take care of that. There is a tremendous
9 amount of this business of differentiation in prices
10 and the savings on generic names which is almost in
11 the same category and should be thrown out as a
12 public nuisance and sometimes they are thrown out.
13 These people very definitely feel they have an axe
14 to grind and we have no way of getting at them.

15 MR. TROTTER: This brings up a problem that
16 we are faced with. Someone calls me up and asks
17 me why it is that they can buy 50 pills for \$7 at
18 a certain drug store and then they will go to another
19 drug store and get the same 50 pills for \$4.75. That
20 person is not trying to be a nuisance but it is
21 an economic problem with him because these drugs
22 cost a lot of money. I know of an instance of
23 that and I know where they got the drugs and they got
24 50 pills for \$7 at one place and at another place
25 they got the same drugs for \$4.75. The druggist
26 who sells \$4.75 must be making money or he would not
27 be in business.

28 PROF. FULLER: If the person can get 50
29 tablets at one place for \$4.75 for goodness sake
30 why not go there and get them and be happy?



1 Why does he have to call you on the phone to say that
2 he can buy drugs at one place for so much and at another
3 place for a different price? Why complain to you
4 about it? Prices in houses go up \$3,000 and that is
5 a whole lot more than \$7 and yet we do not have a
6 legislative committee to examine the increase in the
7 cost of housing.

8 THE CHAIRMAN: Do you think the Committee's
9 efforts are superfluous?

10 PROF. FULLER: No, I would not say they are
11 superfluous.

12 THE CHAIRMAN: For instance, I feel some
13 of the subjects which we have examined have made it
14 a very useful morning. If this Committee had not been
15 in existence it would not have provided a responsible
16 person such as yourself an opportunity to make a very important
17 statement which you did a moment ago. I think it
18 is a very useful thing to hear your views about this
19 so-called public talk and the fact that it is magnified,
20 I take it in your view, out of proportion.

21 PROF. FULLER: I feel sorry for the Committee
22 having to spend so much time as a detective has to
23 spend his time running down these false rumors just
24 as I feel sorry for the people at the airport who
25 have to spend their time making sure that an aeroplane
26 is safe to fly in the interests of society in general.
27 I think your work is very worthwhile and I did not
28 mean to imply that it was not at all.

29 THE CHAIRMAN: I think your answer about
30 the pills costing \$7 and \$4.75 is a fair answer. There



1 is a good example of the problems that Mr. Trotter
2 has and I have and for some reason the public seems
3 to have attached a great deal of attention or importance
4 to this price differential.

5 PROF. FULLER: I would say it is simply
6 part of the responsibility of being a member of Parlia-
7 ment.

8 MR. RICE: We are looking to you to give
9 the members of Parliament some help and I was hoping
10 that your answer before, that the business management
11 of the individual pharmacist, the profit that he
12 desires to make and the cost of the ingredients,
13 how they vary from place to place, could make this
14 a very interesting subject. Would that be a fair
15 answer to give --

16 PROF. FULLER: Apparently I am getting a
17 little tired, could you repeat that?

18 MR. RICE: Well, we went over the three
19 factors that you said entered into the cost of
20 a prescription and I accepted from you that the pharma-
21 cist has an absolute control over the profit aspect,
22 some control with the overhead and also the ingredients?

23 PROF. FULLER: I would say yes. If there
24 is a differential in that \$1.10 operating costs, what
25 I call a transaction cost, it could account for the
26 difference in price of the prescription itself, the
27 difference in what the pharmacist wants for profit,
28 whether 39 cents, 29 cents or 69 cents, thatt would
29 account for it too.

30 MR. RICE: That is what I was getting at and



1 in Mr. Trotter's example here, taking those factors
2 into consideration, would that account for a difference
3 in price?

4 PROF. FULLER: Yes, I would say that and
5 also this is a free enterprise society and each
6 person who runs an organization has a right to do just
7 that. If a pharmacist wants 69 cents and cannot
8 get it then he will fold up and join some other
9 occupation.

10 MR. RICE: So to get back to the man on the
11 street he can, by shopping around, buy his drugs
12 much cheaper one place than another and still get
13 the same quality of drugs.

14 PROF. FULLER: I do not know that I would
15 subscribe to the last phrase there. If a generic
16 name was used, as Mr. White has pointed out, there
17 can be high priced generic names and low priced
18 generic names and there are so many variables. In
19 the main, I suppose it is a rational explanation.

20 MR. RICE: And that leads onto the next
21 one that if a man can do that how does he -- he does
22 not do it very often -- is there anywhere to obtain
23 that information without shopping around from store
24 to store since drug stores do not advertise their
25 prices?

26 PROF. FULLER: No, I see no way at all by
27 which he can get that information.

28 MR. RICE: In your opinion, if the druggists
29 did advertise would it have the effect of equalizing
30 prices and probably eliminating this problem?



1 PROF. FULLER: I am thinking of the College
2 of Pharmacy of Ontario, what they would do if someone
3 attempted to advertise the prices of a prescription.
4 A pharmacist saying "I will charge you so much for
5 twelve aureomycin" is just like a doctor saying
6 "I will charge you so much for taking your tonsils
7 out." You get into this business that is absolutely
8 non-professional and nonsensical.

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2 Now, pharmacies just aren't made that way.
3 We have a few down in the lower part of the United
4 States, in Louisiana, where some of the supermarkets
5 that have no relationship to pharmacy at all did hire
6 a pharmacist and put a little bit of a dispensary in
7 a corner of the room here when the whole organization
8 occupies a city block. They are advertising that
9 way because the State laws are such down there, they
10 are able to advertise.

11 THE CHAIRMAN: You don't have to go to
12 Louisiana. There is an example of one merchant in
13 this city who is expanding his interests. There is
14 no secret about it.

15 PROF. FULLER: Advertising the price of
16 prescriptions?

17 THE CHAIRMAN: Giving an example of a
18 merchandise store going into the pharmaceutical field.

19 PROF. FULLER: Oh, yes, but they are not
20 directly advertising. There are stores in the Southern
21 United States where they put the price of aureomycin,
22 12 capsules so much. They put that right in the
23 newspaper. I wouldn't like to see that.

24 MR. RICE: What would be wrong with
25 advertising the price of drugs that way?

26 PROF. FULLER: Because the dispensing of
27 a prescription is a professional activity, and the
28 prescription is not trade goods. It is written and
29 dispensed for one person, and one person only who cannot
30



1
2 sell it again.

3 You cannot stimulate demand by advertising.
4 Demand is not only assessed in the physician's office,
5 the demand is conditioned by the incidence of any
6 particular disease at any moment of time. You cannot
7 increase the volume of sales of any prescription
8 product simply by advertising. You can increase the
9 sales of many other things that have, what shall we
10 call it, an elastic demand.

11 If you can increase - if you can sell a
12 larger number at a lower price and the total amount
13 that you receive is greater than you can get selling
14 a smaller amount at a higher price, then it would seem
15 economically sound to do it.

16 However, that is only true as far as goods
17 where an elastic demand is concerned, and prescription
18 drugs have an unelastic demand. The demand does
19 not stretch with the price at all. The demand varies
20 with the incidence of disease. Perhaps if we pulled
21 it down to the salt level: A grocery store -- and
22 I have seen this happen -- advertises a two pound
23 bag of salt at 10 cents instead of 15. People are
24 not going to use any more salt because it is 10 cents
25 rather than 15. People may go in and buy a couple
26 bags and put one on the pantry shelf and leave it there,
27 but the production and sale of salt would not increase
28 one jot. It simply takes one sale away from one
29 merchant and gives it to another at a lower price, for
30 one purpose.



1
2 MR. WHITE: You mentioned just before that
3 prescription drugs are not trade goods and yet at
4 the present time they are distributed as if they were
5 trade goods. I have found reference in this
6 Pharmaceutical Journal suggesting that perhaps druggists
7 should dispense drugs at their material cost plus a
8 dispensing fee, and mentions a firm in Winnipeg that
9 is doing that.

10 Do you think yourself that might be the
11 solution to the problem?

12 MR. TROTTER: Would it be convenient for
13 the witness to sit by the mike instead of standing?

14 PROF. FULLER: No, I can think better
15 standing up. That has been my thesis for about three
16 years back to the pharmacists I have written both in
17 the United States and Canada on this subject and I
18 have lectured also. The first paper I delivered to
19 the Pan-American Congress in Washington in 1957, and
20 my suggestion is to get rid of this idea of too many
21 low priced prescriptions and too many high priced
22 prescriptions.

23 If the pharmacists would charge a professional
24 fee of \$2.00 and add the wholesale cost of the ingredients
25 regardless of what they are, that is it, and it is as
26 simple as that.

27 As far as generic name products are concerned,
28 it would be absolutely beside the point from the stand-
29 point of the pharmacists whether a generic name or
30



1
2 brand name; he gets \$2.00 just the same, \$1.10 of
3 which would go towards overhead and his time, and the
4 rest for himself.

5 Perhaps if you will bear with me for a
6 second or so, I may be able to give you some information
7 on it. Taking these same forty-two thousand odd
8 prescriptions that I analysed in the fall of 1957 and
9 the spring of 1958, instead of 1.1 per cent of those
10 prescriptions being dispensed at \$10.00, only 3/10
11 of one percent would be over \$10.00. Of course, I
12 feel no prescription would be dispensed below \$2.00.

13 20.3 per cent of them would have been dis-
14 pensed under \$2.50. I would like to read the
15 cumulative figures as I go along: At \$3.00, 49.2;
16 at \$3.50, 66.8. Now, here is the difference that
17 I think you are looking for: Under the present system
18 75.7% of these forty-two thousand prescriptions were
19 dispensed at \$3.50 or less, some of them being under
20 50 cents. Under this new scheme the exact same
21 prescriptions, 66.8 per cent of them would be dispensed
22 at \$3.50 or less, and none would be dispensed below
23 \$2.00. Now, if we come up to \$5.00 level, it just
24 about evens off there. Under the old system 88.6%
25 prescriptions were dispensed at \$5.00 or less; under
26 the new system 89.9% would be dispensed at \$5.00 or
27 less. You are therefore taking the pressure off the
28 high priced prescriptions and letting the person down
29 in the bottom who has been getting his prescriptions
30



1
2 too cheap pay a percentage of the overhead that I
3 feel the public should pay.

4 This method has not been too popular with
5 many pharmacists. It has been very popular with
6 others. In Winnipeg right now there are forty young
7 pharmacists who have told me personally, face to face,
8 they would like to adopt it right away tomorrow.
9 The rest of the people in the community are not in
10 favour, and this one man in Winnipeg, instead of
11 using this, he says one dollar and the boys in
12 Winnipeg are very much perturbed about it. They
13 asked me to look the situation up. One full-time
14 pharmacist and a part-time pharmacist -- down the
15 street I am told he employs 16 pharmacists. He is
16 getting the prescription business from the other
17 pharmacists in Winnipeg. I have stood in front of
18 the store and counted the people entering the pharmacy,
19 and there were already people in the pharmacy in the
20 prescription department.

21 I don't think the two dollars will be a fair
22 fee all over the United States and Canada, but it
23 could work out to be a fair fee in Canada at the present
24 time. If the overhead increases, you simply increase
25 the fees to \$2.10 and so on. I think it is a very
26 logical way of pricing prescriptions.

27
28 (Page 720 follows)
29
30



1 MR. RICE: Professor Fuller, in Toronto I
2 came across this advertisement:

3 "Are you chronically ill and need medicine
4 regularly? We can save you money. All prescrip-
5 tion drugs sold at WHOLESALe PRICES plus a
6 service fee of \$1.25. For Example: If you are
7 now paying \$6.00 for a prescription at your
8 local pharmacy we can fill it for \$4.25. A \$9.00
9 prescription would cost you \$6.75. The more
10 expensive the medicine, the more you save. Each
11 prescription is filled by a graduate pharmacist
12 registered with the Ontario College of Pharmacy."

13 PROF. FULLER: What paper was this out of?
14 I missed it. I did not see it.

15 Sometime why don't you have a session that
16 is closed to the press so that I can say what I would
17 like to say? Some of the figures in last night's
18 paper are not what I said at all. Some of the people
19 involved are directly behind it.

20 This thing was stirred up in Vancouver by
21 an article in a certain trade paper. Whether some
22 trade paper is responsible for stirring it up in
23 Toronto or not, I do not know. We all read McLean's
24 Magazine in the middle of August, or I think it was the
25 end of August about the patent medicine stores and all
26 this sort of thing, and what was going on in Winnipeg,
27 the discount houses getting into pharmacy.

28 The press will just have to take it, that
29 is all. That is in the nuisance category, the blow-up
30 for the rest of the Canadian people about this situation



1 in Winnipeg. You could find out the kind of prescrip-
2 tion business a pharmacist was doing by going and
3 standing -- they could take relays of shifts, they
4 could take their wives and find out what are the
5 facts of the pharmacies in Winnipeg, without blowing
6 it up and making it worse than it really is.

7 This is common all through our society,
8 even in labour you will find union people who want
9 to break strikes, and you will find scabs and so forth.

10 THE CHAIRMAN: There is always someone
11 rocking the boat somewhere.

12 PROF. FULLER: Yes, even in Ottawa.

13 THE CHAIRMAN: I wonder if this wouldn't
14 be a proper place for us to adjourn. We certainly
15 have had lots of food for thought.

16 MR. WHITE: Could I ask one more question?

17 THE CHAIRMAN: Yes.

18 MR. WHITE: Page 31 shows the total expend-
19 iture on prescriptions last year as being \$130,000,000
20 in Canada. Would you tell us what proportion of
21 that is in Ontario?

22 PROF. FULLER: Yes, I did in the early
23 part of the paper on Page 3, \$42,022,833.

24 Might I in answer tell you how I arrive at
25 that? I think we should all be aware of the limitations
26 of statistics here.

27 We take 511 pharmacies. We get their
28 ratios of each expenditure to total sales and so on
29 all the way through. We divide by 511 to get an
30 arithmetical average from this sample. I contacted



1 every registrar of every province in Canada and asked
2 how many pharmacies were registered as of the last
3 day of December 1959. They all replied and I added
4 those up and I multiplied that by the average and that
5 gives my total volume of sales.

6 I had two or three other techniques which
7 gave me a total that deviated slightly. I added the
8 four totals together and divided by four and I was
9 able to come up with an average of \$503,000,000 which
10 is approximately \$100,000,000 more than the Dominion
11 Bureau of Statistics figure.

12 In the same way they gave me the amount of
13 money they received from prescriptions and I calculated
14 that as a percentage of sales. Then I simply
15 projected that, because the pharmacists want to
16 have some idea and find out what we have at our
17 disposal.

18 When it comes to allocating this \$130,000,000
19 for prescriptions among the provinces, we have a
20 problem. Dr. Willard of the Department of National
21 Health and Welfare in Ottawa a few years ago used these
22 figures to try and get at that. The Federal government
23 wanted to know if they could have a progressive health
24 plan, and how much it would cost to the Province to
25 supply drugs.

26 He suggested two different methods by which
27 they could allocate the average projection, and divide
28 it up amongst the provinces. I was asked in a per-
29 sonal letter if I would pass judgment on these two
30 methods and select one or the other as being the best,



1 and if I couldn't, to devise a third method.

2 I did about three weeks hunting and so on
3 and eventually took the census distribution as my
4 source of distribution of sales of prescriptions in
5 pharmacies in the various provinces and Canada.

6 I had the total volume of retail trade which
7 gives the volume of prescription business per province
8 for the year 1951, and I took this in ratios existing
9 in 1951, and I applied it to the provinces.

10 I took that same ratio, if I remember correctly,
11 it is approximately 30.2 per cent. We figured that
12 back and that is the ratio it is based on, the distri-
13 bution as set forth in the last census of Canada.

14 MR. WHITE: My last question is this:
15 Would the retail druggists dispense half of the drugs
16 in the Province of Ontario or what proportion, do
17 you think?

18 PROF. FULLER: Would the retail pharmacists
19 dispense half of the drugs that are used in the Province?

20 MR. WHITE: Having in mind that the
21 hospitals are using drugs.

22
23
24
25
26 Page 730 follows.
27
28
29
30



1 PROF. FULLER: I would say perhaps more than
2 that. Ask me that question first, instead of making
3 that statement. Let me look it up. I would like to
4 get the facts.

5 THE CHAIRMAN: Would you like to take that
6 under advisement?

7 PROF. FULLER: Yes.

8 THE CHAIRMAN: We will be asking the same
9 question of the manufacturers to see if they can
10 assist us in ascertaining what our total drug bill is.

11 PROF. FULLER: I would like to warn you
12 in making the comparison that I think you already have
13 evidence that many manufacturers in selling drugs to
14 hospitals give them a very much healthier discount
15 than they give to the retail pharmacies so that in
16 reality you should get how many thousands of pounds
17 of antibiotics of such and such a kind and how many
18 thousands ---

19 THE CHAIRMAN: We are aware that there is
20 a reconciliation involved.

21 PROF. FULLER: May I say, gentlemen, that
22 it has been a pleasure to be here. I hope I haven't
23 been too presumptuous or overstepped the mark at any
24 place. It has all been in the interest of helping you
25 as much as possible.

26 If there is any specific information that I
27 can round up for you, if you can let me know in
28 advance, I would be very happy to try and get it for
29 you.
30



1 THE CHAIRMAN: Thank you, Professor Fuller,
2 for coming. It has been very helpful.

3 This hearing is adjourned to October 19th
4 in this room at, shall we say, 10.15 in the morning.

5
6 ---Adjournment.
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K. Fryden

Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO ONTARIO

VOLUME No.:

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings held
at Parliament Buildings,
Toronto, Ontario, on Wednesday,
the 19th day of October, 1960,
at 10.15 a.m.

COMMITTEE:

MR. H. L. ROWNTREE, Q.C. Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G. F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE, Committee Counsel



1 ---On resuming at 10.15 a.m., October 19, 1960.

2
3 THE CHAIRMAN: Gentlemen, we will resume
4 our hearings this morning, and we have the Committee
5 Members present and some interested persons.

6 Now, what is the agenda, Mr. Secretary?

7 THE SECRETARY: Mr. J. W. T. Michel,
8 Commissioner of Patents from Ottawa, is on this
9 morning.

10 THE CHAIRMAN: From the Federal Government?

11 THE SECRETARY: From the Federal Government.

12 MR. WILSON (President of the Ontario Retail
13 Pharmacists Association): Mr. Chairman, just before
14 you commence the regular proceedings, I wish to inform
15 the Committee that the Ontario Retail Pharmacists
16 Association is working on a submission which we hope
17 will not only help the Committee but also the public
18 in determining the position of the pharmacists as
19 members of the health team, and we would look forward
20 to making this submission at a future meeting of the
21 Select Committee.

22 THE CHAIRMAN: I am very happy to receive
23 that statement, Mr. Wilson, and thank you for coming
24 this morning to make it.

25 MR. WILSON: Thank you.

26 THE CHAIRMAN: Is there any other business
27 before we proceed?

28 THE SECRETARY: We have heard from the
29 Royal College of Dental Surgeons, Mr. Chairman, and
30 they desire to assist the Committee and to make



1 presentations, and they have information that they
2 feel will be of great assistance and are preparing a
3 brief on behalf of the dentists and will present this
4 at one of our forthcoming meetings.

5 THE CHAIRMAN: I am very happy to receive
6 those two statements; and I might say to both the
7 pharmacists, the practising pharmacists and dentists
8 and any other parties who are concerned or feel that
9 they might be concerned with the proceedings of this
10 Committee, that the facilities and the offices of
11 this Committee are available to them, through our
12 Secretary, through our counsel, through our chartered
13 accountant. Any of our facilities are available to
14 anyone who wishes to use them to assist in presenting
15 any information to this Committee.

16 Mr. Wilson, would you convey to the Royal
17 College of Dental Surgeons the Committee's position in
18 this matter: if we can help them in any way we shall,
19 and we shall be very happy to receive their submissions
20 at a future date.

21 MR. WILSON: Yes, Mr. Chairman.

22 THE CHAIRMAN: Is there any other infor-
23 mation?

24 THE SECRETARY: No. The meeting is to go on.

25 THE CHAIRMAN: What is the agenda for
26 tomorrow?

27 THE SECRETARY: Tomorrow at 10.15, Dr. Morrell
28 of the Food and Drug Directorate from Ottawa; 10.00 a.m.
29 on October 21st, Dr. Ferguson, Director of the
30



1 Connaught Laboratories. That is all for this week.

2 THE CHAIRMAN: What is to be the position
3 with respect to next week?

4 THE SECRETARY: Commencing next week, on
5 October 24th, the Pharmaceutical Manufacturers'
6 Association.

7 THE CHAIRMAN: Where do the non-members fit?

8 THE SECRETARY: They come in after when we
9 determine how long they wish to have to present their
10 brief. I understand there are two independents who
11 expressed a wish to appear.

12 THE CHAIRMAN: Have you any idea how long
13 the Pharmaceutical Manufacturers' brief will take?

14 THE SECRETARY: I believe, sir, we will have
15 two days with them. They have a presentation of
16 perhaps 70 pages, the first one, which they intend to
17 read, and a study has been made by an economist and
18 they will have him speak and make the presentation.
19 So I think it will run into Tuesday.

20 THE CHAIRMAN: Now, as to the Pharmaceutical
21 Manufacturers' brief, wouldn't it be desirable,
22 gentlemen, if we had that brief in advance? We can't
23 appraise it ---

24 THE SECRETARY: I expect to have the brief
25 on Thursday of this week.

26 THE CHAIRMAN: Will you be able to get it
27 into the hands of the Committee?

28 THE SECRETARY: Yes.

29 THE CHAIRMAN: I think you will understand
30



1 that if the brief is of that size and magnitude then
2 we should at least have the opportunity of reading it
3 to prepare ourselves for the presentation.

4 THE SECRETARY: Well, we have two days and
5 the week-end to look it over.

6 THE CHAIRMAN: Well, for the hearings next
7 week you suggest two days for the Manufacturers?

8 THE SECRETARY: I think so, sir.

9 THE CHAIRMAN: Do you think that is long
10 enough?

11 THE SECRETARY: Well, it depends on the
12 questioning, sir. It could go three, but as far as I
13 am concerned I think it might be over in two days.

14 THE CHAIRMAN: Do you have any knowledge of
15 the two independent manufacturers who have indicated a
16 desire to be present?

17 THE SECRETARY: Mr. Gilbert, who was here,
18 said he is preparing the brief, and we gave him the
19 date and he said he would like the 27th.

20 THE CHAIRMAN: Mr. Gilbert is not here.

21 THE SECRETARY: He thought he would like the
22 24th, but as we had this previous commitment, it
23 couldn't possibly be before the end of the week.

24 THE CHAIRMAN: Have you any indication from
25 the second independent manufacturer?

26 THE SECRETARY: Yes. On the phone he thought
27 he would like to appear, give a small brief. That was
28 Paul Mane Laboratories. Mr. William Miller, I believe,
29 is the president, and he thought he would make a
30



1 presentation, invite the Committee to visit the plant
2 and see how their controls were being made.

3 THE CHAIRMAN: Has he indicated to you ---

4 THE SECRETARY: No date, sir.

5 THE CHAIRMAN: Has he indicated to you, not
6 the content but the extent of his brief or of his
7 presentation?

8 THE SECRETARY: No, sir.

9 THE CHAIRMAN: Gentlemen, would it be
10 reasonable to suggest to the Secretary that he contact
11 this gentleman and see what they have in mind?

12 MR. LAVERGNE: Mr. Chairman, if I understand
13 correctly, on the 24th, I believe we meet on the 24th,
14 and there is to be a presentation of a 70-page brief;
15 is that correct?

16 THE CHAIRMAN: I gather it is closer to 120
17 page.

18 MR. LAVERGNE: You had suggested we have this
19 previously. I think it is only logical that we have it
20 a couple of days ahead of time.

21 THE CHAIRMAN: Any other comments?

22 MR. WREN: What days would we be meeting?

23 THE CHAIRMAN: That is what I am trying to
24 determine. We are going to give three appointments
25 this week, today, tomorrow and Friday.

26 THE SECRETARY: One definitely starting
27 Monday which could run two to three days.

28 MR. BOYER: Will we be meeting again in
29 November?
30



1 THE CHAIRMAN: I think the public is entitled
2 to a statement as to what the Committee's position is.

3 The next session of the Legislature will
4 convene on November 22nd, and at that date this
5 Committee will, by law, be dissolved and be of no
6 validity. There will be an interim report which this
7 Committee will present to the House. The report will
8 state what the Committee has done briefly, but it
9 will also ask that the Committee be reconstituted, and
10 I would expect that the Government and the House would
11 reconstitute this Committee in accordance with the
12 request in order that we can complete our investigation
13 and submit our final report.

14 Now, the reason we are talking about the
15 agenda is this, that many of our members are from out
16 of town, and if the house is to sit on November 22nd,
17 the members from out of town must return to their
18 constituencies and complete their local obligations to
19 their electors, and I would think that next week would
20 see the end of the sittings of this Committee.

21 Now, does anyone have any comment on that?
22 In other words, what I am saying is that after we
23 hear the Manufacturers' brief, with or without the
24 two independent companies, being non-members of the
25 Pharmaceutical Association, that would complete the
26 Committee's work at the end of October, leaving three
27 weeks for the members to return home and then come back
28 for the sitting of the Legislature.

29 Are there any comments on that?
30



1 MR. PRICE: What about the preparation of
2 the interim report? Will the whole Committee have to
3 convene?

4 THE CHAIRMAN: I am glad you raised that.
5 I think the interim report will simply be a report that
6 we sat so many days, we proceeded with our investiga-
7 tion, and we have had certain witnesses. We couldn't
8 bring in a conclusion. I think we simply report what
9 we have done. It is a formal matter, and there would
10 be no substance to the report.

11 MR. PRICE: It won't be necessary to bring
12 the Committee together to have the report prepared?

13 THE CHAIRMAN: I would think a draft
14 report might be prepared next week when we are here
15 so that you can all see it.

16 MR. BRYDEN: When do you expect the replies
17 of the Hospital Questionnaire will receive considera-
18 tion?

19 THE CHAIRMAN: Mr. Gadsby, how many hospitals
20 were circularized in respect to the questionnaire?

21 THE SECRETARY: 169 completed the returns.

22 THE CHAIRMAN: Out of how many?

23 THE SECRETARY: 283.

24 THE CHAIRMAN: What was the date for filing?

25 THE SECRETARY: The 12th of October. We
26 have had correspondence with these people, many of them,
27 for clarification on some of the questions asked, and
28 those people with whom we have been in communication
29 will be sending in their returns, and there will be
30



1 quite a few, but possibly next week the follow-up
2 letter will be going to the others.

3 THE CHAIRMAN: Will it be agreeable to
4 sending a hastener to those who didn't reply?

5 Any objection to that? I would be glad to
6 speak to you, Mr. Secretary, about the form or nature
7 of the reminder.

8 MR. BOYER: Is it two days next week?

9 THE CHAIRMAN: It could be three days, Mr.
10 Boyer, as I see it.

11 Does anyone else have anything to add about
12 the agenda or proceedings? Anyone in the audience have
13 anything to add?

14 There being no reply, we will now call upon
15 Mr. Michel, who is the Commissioner of Patents, which
16 is a Department of Government under the Department of
17 the Secretary of State of the Federal Government.
18 Mr. Michel appears here through the courtesy of his
19 Minister, and we are concerned with the question of
20 patents in so far as they relate to drugs; also having
21 in mind the licensing feature of drug patents, always
22 having in mind the objective and the target of the
23 Committee, which is to consider the cost factor and
24 the cost of drugs to the public.

25
26
27
28 --- (Page 742 follows.)
29
30



1 Before Mr.Michel proceeds, I think I should
2 say this, that as the Commissioner of Patents, Mr.
3 Michel occupies a very senior and authoritative position
4 in the Federal Government. It must be obvious and
5 apparent to all of us that Mr.Michel cannot speak
6 on matters of cost.

7 In the same spirit that we express our thanks
8 to him for coming here, I am sure you will all appreciate
9 that any examination of Mr. Michel cannot go to the
10 question of government policy at the federal level.
11 I put that to you frankly and squarely, gentlemen,
12 and to those members of the public who are present.

13 MR.RICE: How long have you been Commissioner
14 of Patents?

15 MR. MICHEL: Slightly over ten years.

16 MR. RICE: How long have you been associated
17 with the Patent Office?

18 MR. MICHEL: Since the 27th of June, 1929.
19 Slightly over 31 years.

20 MR. RICE: What Act governs the work in
21 the Patent Office?

22 MR.MICHEL: The Patent Act, Chapter 203 of
23 the Revised Statutes.

24 MR. RICE: That is of Canada?

25 MR. MICHEL: Of Canada, yes.

26 MR. RICE: And the Chairman has said it is
27 under the jurisdiction of the Department of Secretary
28 of State?

29 MR. MICHEL: Yes, sir.

30 MR. RICE: This Committee is concerned with



1 drugs and medicine. Can a drug or medicine be
2 patented?

3 MR. MICHEL: Under conditions. Section 41
4 of the Patent Act says that -- I think I had better
5 read the section to you:

6 "In the case of inventions relating to substances
7 prepared or produced by chemical processes and
8 intended for food or medicine, the specification
9 shall not include claims for the substance itself,
10 except when prepared or produced by the methods or
11 processes of manufacture particularly described
12 and claimed or by their obvious chemical equivalents."

13 That means, sir, whenever a new drug is
14 discovered, the applicant cannot get protection for
15 same on that product without that product was made
16 by chemical process. The process is patented, but
17 the drug itself is not patented.

18 THE CHAIRMAN: Would you expand on that?

19 MR. MICHEL: Yes, I will, because I think
20 it is necessary to expand on that. If it is a mixture
21 or an extraction process, a drug that has been extracted
22 from natural products by distillation -- for instance,
23 you don't call that a chemical process. They can
24 get by a mixture of several drugs together which produce
25 a result unexpected -- if you put two drugs together,
26 they have a reaction, for instance, that the mixture
27 gives you a result which is not to be obtained by the
28 administration of each drug separately. Then you
29 might have a patentable subject matter. You might --
30 you can cover that composition.



1 Now, I said chemical processes. This is
2 a very, very touchy matter. It is a very difficult
3 matter. Chemical processes, when you talk about
4 substances, drops, you might say they are all produced
5 by chemical process. As I just said, you may get
6 that by extraction in which there is no chemical
7 reaction. You might purify and have a substance
8 with no chemical reaction. You can also obtain it
9 by fomentation, by the use of micro-organisms. The
10 chemical reaction is not brought about by the hand
11 of man. That is by putting the reactive A, which
12 reacts in B. You put a micro-organism in and it acts
13 -- nature does it.

14 Up to 1941 there was no clear-cut decision
15 in that, but you will find that in the case of J. R.
16 Short Milling Company (Canada) Limited versus George
17 Weston Bread and Cakes Limited et al, this is reported
18 in the 1941 Exchequer report 69, and also in Fox
19 Patent Cases, Volume 1, 1940-41, page 48.

20 Justice Maclean of the Exchequer Court says
21 this -- may I read the passage here? I think it will
22 be clearer.

23 "The major difficulty in construing Section
24 40 (1)..."

25 He is talking about Section 40, (1). At that time
26 it was Section 40. Now it is Section 41.

27 "arises from the employment therein of
28 the words 'chemical process', without attempting to
29 to define the term, or without limiting its application.
30 A statutory use of the words 'substances prepared or



1 produced by chemical processes and intended for food'
2 immediately suggests the inquiry as to whether the
3 Legislature, or the draftsman, intended those words
4 to be construed in the sense which the chemist or physi-
5 cist might construe them, or whether they are to
6 be construed in what I might call the popular sense,
7 which would give them a much narrower meaning. Prac-
8 tically every substance intended for food, may be said
9 to have been either prepared or produced by a chemical
10 process, as is all living matter, but did the Legislature
11 approach the enactment of s. 40(1) according to the
12 conceptions of theoretical chemistry and thus open
13 up a field of interminable controversy, for a
14 purpose concerned with the administration of the law
15 relating to patents, the necessity for which, in my
16 opinion, is open to serious debate? In the scientific
17 sense it is probably impossible to classify phenomena
18 in a rigorous manner, because border-line cases always
19 exist and natural phenomena refuse to allow themselves
20 to be classified into arbitrarily defined groups. I
21 should think it doubtful if it were possible to decide
22 always, with entire satisfaction, what is a chemical
23 process and what is a non-chemical process. In the
24 strict sense virtually everything involves a chemical
25 process and therefore if this viewpoint is carried
26 to the limit s. 40(1), which purports to distinguish
27 between chemical and non-chemical processes in preparing
28 or producing substances intended for food or medicine,
29 becomes almost meaningless."
30



1 And he goes on, and that case I might explain
2 was for substances and methods of bleaching flour.
3 Raw flour. Up to that time several methods had been
4 used. The inventor found out if he should take the
5 soybean and dried out the soybean, under very mild
6 conditions, he obtained a substance -- there remained
7 a substance in the bean, which, when added to the flour,
8 will bleach the flour.

9 "I am unable to accept the view that the
10 flour bleaching material of Haas is a 'substance'
11 prepared or produced by a 'chemical process', and I
12 think it is the only 'substance' here to which
13 s. 40(1) could have any application. It is a
14 vegetable material containing a bleaching enzyme,
15 prepared mechanically and without the intervention
16 or aid of any substance of a chemical nature
17 intended to effect any particular reaction, and
18 is not, I think, a material prepared by a method
19 which might fairly be said to involve a chemical
20 process set in motion by human agency, which, I
21 think, the statute must have contemplated when
22 it speaks of 'inventions relating to substances
23 prepared or produced by chemical processes".

24 From then on, the Patent Act -- we had, I
25 might say, granted a patent on this assumption. When
26 I came to the Department back in 1929 those were the
27 instructions which were given me. Although I had
28 not myself signed this patent, it was signed on my
29 direction, and it went to Court, and we had the decision.
30 We were very glad to have it because we didn't know



1 exactly where we were, and we were lacking in jurisprudence,
2 but we were not getting anywhere.

3 Great Britian had more or less the same type
4 section, 39(a) at that time. It has not been changed.
5 Ours was equivalent to theirs.

6 THE CHAIRMAN: What you are saying and
7 stating to the Committee, might we regard this
8 decision as one which describe the guiding principles
9 having to do with administration and application of
10 patents.

11 MR. MICHEL: Yes, sir. Yes, Mr. Chairman,
12 yes. That was the gauge we were following before,
13 and our hand was strengthened. Our directive was given
14 so that we were very glad to have that directive
15 from the Court. Before that, well, we thought we
16 were right, but there was no confirmation.

17 THE CHAIRMAN: The result of this judgment
18 in the case you have cited, concerns; would it be --
19 it is not common law - it would be an interpretation
20 of the Patent Act with respect to the interpretation
21 of this subject matter.

22 MR. MICHEL: Yes, sir. Yes, Mr. Chairman.

23 MR. RICE: The case you cited defines what
24 a chemical process within the meaning of the Act
25 is.

26 MR. MICHEL: Oh, yes, yes. They were very
27 careful on that.

28 MR. RICE: As you pointed out earlier, the
29 process is patentable, and not the drug itself; is
30 that correct?



1
2 MR. MICHEL: Right. That involves another
3 thing there. If we have an application on hand whereby
4 the chemist put substance A with substance B, and
5 and he gets substance C, then you have distinctly
6 a chemical process. That process may be patentable,
7 but the product resulting from it is not patentable.
8 But it is according to this interpretation of the Act
9 if someone comes to the Patent Office with an application
10 claiming a fomentation process or another process
11 to arrive at a substance, then we use this ruling,
12 and if the process is patentable, we give a patent
13 on the process and also a patent on his product. Because
14 the product has not been made by chemical process or
15 directed by Section 41 (1).

16 MR. RICE: So that if a drug can be produced
17 by two distinct chemical processes, can each one
18 of those chemical processes be patented?

19 MR. MICHEL: Oh, yes, yes, provided each
20 process is patentable. So that if I may add here
21 when a company has a patent or claim to have a patentable
22 drug which has been made by chemical process, they
23 can stop anyone from making that drug. They can stop
24 anyone from using that process, and what the other people
25 have to do is to look and try to find another way,
26 another process of making that drug, and of course
27 the patent protects the processor.

28 If somebody went or tried to import a drug
29 which actually is not protected in Canada, he can be
30



1 stopped in Section 41 (2) which says:

2 "In an action for infringement of a patent where
3 the invention relates to the production of a new
4 substance, any substance of the same chemical
5 composition and constitution shall, in the absence
6 of proof to the contrary, be deemed to have been
7 produced by the patented process."
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21 Page 752 follows.
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2 So that the importer will have the proof
3 that the substance that he has imported had not been
4 made abroad by the patented process in Canada.

5 THE CHAIRMAN: Mr. Michel, does this
6 mean in effect that the Patent Act has application,
7 not only to goods made in Canada but to those made
8 outside of Canada and imported into this country?

9 MR. MICHEL: Well, the Patent Act does
10 not purport to apply to other countries but when it
11 is actually taken, it is taken in Canada, and the Act
12 says that the substance which has been imported is
13 deemed to have been produced by the process which is
14 protected in Canada.

15 So that the defendant has the onus of
16 proving that the drug has not been made by that same
17 process. I do not know of any case personally. I
18 think there might have been cases, but I was talking
19 to a lawyer the other day, as a matter of fact, one
20 of my friends in Ottawa, who went to Holland to take
21 testimony. He did not tell me exactly what it was,
22 but the way he was talking, I think he was the
23 defendant in court and he went over there to take
24 testimony and came back and tried to prove that another
25 process had been used.

26 MR. LAVERGNE: Before we go any further,
27 Mr. Rice asked a question and I think it was that
28 where substance A is already a patented drug, where
29 you were speaking of substance A, substance B, and the
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2 using of substance A and substance B produces
3 substance C. I just wanted to get this straight.
4 I think Mr. Rice asked the question, if both were
5 already patented drugs in that sense.

6 MR. MICHEL: Not quite. The question
7 as I understood was, can drugs be patented in Canada?

8 MR. LAVERGNE: But previous to that,
9 Mr. Rice directed a question, I believe, of substance
10 A and substance B being patentable drugs, and maybe
11 the amalgamation of these two would produce substance
12 C, which in itself may be a drug, whether it be
13 patentable or not. What I am trying to get straight
14 is, are we assuming that substance A, as you define
15 it, is already a drug and a patented drug and
16 substance B the same?

17 MR. MICHEL: I would say that in most
18 cases substance A and substance B will not be drugs
19 in themselves.

20 MR. LAVERGNE: Not in themselves?

21 MR. MICHEL; No, it could happen that
22 he would take two substances that have some effect
23 and react together to get a third drug. It could
24 happen, but it is rarely the case, but substance A
25 and substance B could be substances that have no
26 medicinal properties, and they still could be
27 patented for industrial processes, or they could be
28 in the open.

29 THE CHAIRMAN: Mr. Michel, does that
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1
2 mean that the application of the Patent Act, and we
3 are talking about that know, about patents -- when
4 we say "patents", we are talking about the application
5 of the Act -- that it is the process that can be
6 patented and not the result?

7 MR. MICHEL: When we are talking about
8 drugs?

9 THE CHAIRMAN: Yes.

10 MR. MICHEL: When we are talking about
11 drugs, but when we are talking about industrial
12 products, then the products themselves are patented.
13 The process and product are patentable if they are
14 not intended at the time of application for food or
15 medicine.

16 THE CHAIRMAN: Not intended?

17 MR. MICHEL: Not intended at the time of
18 application for food or medicine, and that brings in
19 another matter I must explain.

20 THE CHAIRMAN: May I just interject for
21 one second and say this to you that for the purpose
22 of our Committee, I think it is only fair to tell you,
23 that we are laymen, that we are dealing in matters
24 of the wording of a piece of legislation, and also
25 in the vocabulary of a highly developed subject such
26 as drugs, with which frankly none of us are familiar.

27 That is the difficulty under which we as
28 a Committee labour, and if you talk to us in laymen's
29 terms, it would perhaps be better.
30



1
2 MR. MICHEL: I appreciate, and I will
3 try to do my best. If you don't understand, go ahead
4 and ask questions.

5 MR. RICE: Mr. Michel, could you give
6 the Committee any estimate or any figure as to how
7 many drugs there are that have valid patents today,
8 drugs or medicines?

9 MR. MICHEL: If I might, I will correct
10 your wording. Valid patents, insofar as the
11 Commissioner of Patents is concerned, he thinks all
12 patents are valid. Do you mean patents in force?

13 MR. RICE: Patents in good standing.

14 MR. MICHEL: Section 83 of the Act says,
15 "Any patent granted by the Commissioner
16 is prima facie valid."

17 In answer to your question, there are
18 probably roughly in force now in Canada in all fields
19 of drugs, I would say, roughly about 1,000 to 1,200
20 patents. That is a guess but I think I am pretty
21 close, I might say, as of the 24th of February, 1960.

22 There were 430 patents and antibiotics.
23 I say this from a report I had to make at that time.

24 THE CHAIRMAN: Will you just repeat that
25 last sentence?

26 MR. MICHEL: As of February, 1960, there
27 were 430 odd patents and antibiotics. That is a
28 report I had to make to my Minister at that date.

29 MR. WREN: How long will they remain in
30



1
2 force.

3 MR. MICHEL: For seventeen years. All
4 patents in Canada remain in force for seventeen years.

5 MR. LAVERGNE: Could you broaden that?
6 What do you mean by "remaining in force"? Isn't a
7 patent good for all time?

8 MR. MICHEL: No sir, a patent is a
9 reward given by the government to an inventor for
10 disclosing his invention to the public. This reward
11 takes the form of an exclusive right to deal with the
12 invention.

13 Personally, I have been at the game for
14 a long time, and I think it is a negative right. If
15 you look at the last amendment of the last act, when
16 the Assistant Commissioner talked to me back in 1951,
17 we spent many nights discussing patents, and that
18 was my opinion, that patents are negative rights, and
19 they have included that in their act of 1953. A
20 patent is a right to prevent others from doing what
21 belongs to you, to prevent others from using your
22 invention.

23 MR. WREN: For seventeen years?

24 MR. MICHEL: For seventeen years. The
25 term of seventeen years is more or less arbitrary.
26 I don't know if you want me to go back to the beginning
27 of it, but I can do that for you.

28 It seems that in the sixteenth century in
29 England, at the time of the guards, an apprentice
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2 went to a master, and his contract was for seven years
3 to learn the trade. The next seven years were to
4 be spent working for the master. That made it
5 fourteen years. During the next seven years he could
6 practice on his own but not in the district where the
7 master lived. So that made it twenty-one years
8 where the master was protected.

9 Apparently, with the Act of Monopoly in
10 1623 in England, that is where they got the idea of
11 giving the patent protection for three terms of seven
12 years. Then they gradually amended that, and it is
13 down now to sixteen years in Great Britain. In most
14 countries of the world where they have patents it is
15 much less, it runs anywhere from fifteen to twenty
16 years.

17 Our term is seventeen years. In the
18 United States it is seventeen years and in England
19 it is sixteen. Argentina has fifteen, and Germany
20 has sixteen, and France twenty. They are all about
21 the same time.

22 By popular reasoning, it is this way.
23 The government gives this exclusive right for that
24 limited period of years. The reasoning behind it is,
25 "Well, you have an invention. We will give you an
26 exclusive right on it. If in seventeen years your
27 invention is good, you should have reaped your
28 reward during the first seventeen years. If you have
29 not done anything with it, the invention is no good,
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1
2 and there is no use clogging the records and
3 preventing the public from using it."

4 After seventeen years -- it runs for
5 seventeen years -- and you can prevent others from
6 using it. After that it falls to the public domain
7 and anybody and everybody could use it without any
8 hindrance whatsoever, without paying royalties or
9 anything. Within that seventeen years, the use of
10 the knowledge or invention is unrestricted --

11 THE CHAIRMAN: It is restricted?

12 MR. WREN: As far as the inventor is
13 concerned.

14 MR. MICHEL: It is restricted as far
15 as he is concerned. I want to make sure of what you
16 mean.

17 THE CHAIRMAN: What I mean is, could
18 he dictate his own terms for its use during that time?

19 MR. MICHEL: Yes, to a point. It is
20 unrestricted except for the provisions of Sections
21 67 and 72 of the Patent Act. He has the obligation
22 to start manufacturing in Canada within a period of
23 three years, and he must also sell it at a decent
24 price, a reasonable price. He must supply the
25 Canadian market at a reasonable price. If he does
26 not, I bring your attention to Section 67. If he
27 does not, anyone willing and capable of manufacturing
28 the invention can apply to the Commissioner of Patents
29 for a compulsory licence.
30



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2 THE CHAIRMAN: Does the act define
3 a reasonable price?

4 MR. MICHEL: No, it does not define a
5 reasonable price.

6 THE CHAIRMAN: It is at the discretion
7 of the Commissioner?

8 MR. MICHEL: If the demand for the
9 patented article in Canada is not being met to an
10 adequate extent and on reasonable terms.

11 THE CHAIRMAN: Who makes that decision,
12 the Commissioner of Patents?

13 MR. MICHEL: The Commissioner of Patents,
14 but as far as I remember, as far as I know there have
15 never been any applications for compulsory licences
16 in Canada on account of the fact that the price was
17 too high. There have never been. Most of the
18 applications are on account of the fact that the
19 invention is not being manufactured in Canada.

20 THE CHAIRMAN: In the matter of drugs
21 with which we are primarily concerned, is any group
22 or person able to approach you with concern about the
23 price at which any particular drug which was patented
24 being unreasonable?

25 MR. MICHEL: Let me explain, sir, what
26 I have told you about Section 67 and the general
27 provisions of the act.

28 There is Section 41 of the act which is
29 a direct restriction on the exclusive right given to
30



1
2 the inventor. In the case of drugs, you don't have
3 to wait three years before you ask for a licence.

4 There is Section 41, subsection 3, which reads:

5 "In the case of any patent for an invention
6 intended for or capable of being used for
7 the preparation of food or medicine, the
8 Commissioner shall unless he sees good
9 reason to the contrary -"

10 That leaves quite a bit of onus on the Commissioner.

11 "---grant to any person applying for same
12 a licence limited to the use of the
13 invention, for purposes of preparation or
14 production of food or medicine, but not
15 otherwise."

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19 (Page 762 follows)
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1 MR. MICHEL: And then it goes on, setting
2 the terms there. He must fix the amount of royalty,
3 to reward the inventor, make the field of medicine
4 available to the public at the lowest possible price
5 and in the case of the drug even if the patentee,
6 the owner of the patent starts manufacturing right
7 away after he gets his patent, or even before he gets
8 his patent, then anyone willing and capable to manu-
9 facture in Canada can come to me and ask for a licence.

10 The curious thing about it is that these
11 provisions have been in the Statutes since 1923 and
12 when I took over as Commissioner of Patents in May,
13 1950 there had not been one licence granted. There
14 was one application pending at that time.

15 MR. WREN: That is for drugs?

16 MR. MICHEL: For drugs.

17 MR. WREN: Have there been any since?

18 MR. MICHEL: Yes, there have been 14 applica-
19 tions. I have the thing here. My secretary made it
20 out a couple of months ago. There have been 14 so far,
21 in the last ten years I have granted. 5 have been
22 granted. Naturally these provisions, as Mr. Chairman
23 said a while ago we are all laymen here. I don't
24 blame you to be laymen in connection with patents.
25 It's a terribly complicated affair. Naturally if you
26 are laymen in patent matters, most of the Canadian
27 manufacturers are also laymen unless they are big
28 enough to have patent counsel or patent departments.

29 Well now, you hear "Oh you can get a licence."
30



1 Just go to the Commissioner and get permission."
2 Sometimes they phone me and in Winnipeg, Montreal,
3 Toronto, phone me. Want to start manufacturing such
4 and such a substance tomorrow. Give me permission?
5 Nothing you can do about that. Out of that there are
6 applications, not by telephone. There are formal
7 applications which have been made which were informal,
8 and I explain to them what they had to do and in most
9 of the cases where the applications were refused,
10 the applicant could not manufacture. We do not grant
11 licences for distributors, for instance. A licence
12 is to manufacture. The word "use" in the section 41(3)
13 means make, use, and sell.

14 THE CHAIRMAN: Mr. Michel, at this point may
15 I ask you this question: from what you have said I
16 gather that the incidence or frequency of applications
17 for patent protection with respect to the general
18 subject matter of drugs is fairly limited, and I
19 should probably continue the explanation of my question.
20 I have in mind the field of man-made fibres; so-called
21 synthetic fibres, the polyester groups and those
22 others and in that field it is my information that
23 literally every step of the way of the process is
24 patented and without mentioning the manufacturer or
25 researcher concerned, within the United States and
26 Canada there are actually thousands, hundreds -- let me
27 be conservative and say hundreds of patents with
28 respect to each step of the way on those man-made
29 fibres. In the spirit in which I am discussing this,
30



1 would I be right in that statement?

2 MR. MICHEL: Well, when you say that there
3 may be hundreds in each hundred patent covering each
4 step that might be going a little bit too far, but
5 there are a great deal, a great number of patents
6 and practically everything which is worth covering is
7 covered.

8 I think the statement you were after is the
9 fact that we are trying -- were you not trying to
10 compare ---

11 THE CHAIRMAN: Man-made fibre industry to the
12 drug industry.

13 MR. MICHEL: The incidence of application
14 for patents in industry, in chemistry, in man-made
15 synthetic fibres with the incidence of application for
16 patent for drugs. That would be very, very hard to say;
17 be very hard to say. It might be that the incidence
18 is higher than in drugs in other fields of chemistry;
19 the incidence of application for patent may be higher
20 than in drugs.

21 THE CHAIRMAN: Higher in drugs?

22 MR. MICHEL: Than in drugs.

23 THE CHAIRMAN: Than in drugs?

24 MR. MICHEL: Yes.

25 THE CHAIRMAN: In other words, the incidence
26 is less in the drug field than in some other field?

27 MR. MICHEL: Yes. The explanation of this,
28 I would say in chemistry, myself, is the fact that
29 those industries making research in the synthetic
30



1 fibres, synthetic plastic and resins, they are
2 working in their own field all the time. They are
3 working in that field so that practically everything
4 they produce might lead to some results. Whereas,
5 in the pharmacy field they are working in the dark.
6 They have to try hundreds of things before they will
7 learn something which is good so that they come to a
8 dead alley probably, I don't know, I would say at
9 least a hundred times to one, a hundred pieces of
10 research will lead to nowhere although they claim that
11 the incidence is less than that. They claim that they
12 have much more research than that. It is possible
13 that the incidence of applications in the drug field
14 is not as high as in the industrial field.

15 THE CHAIRMAN: Well, here we are interrupting
16 Mr. Rice's trend, and I think we better go back to
17 Mr. Rice.

18 MR. RICE: Well, you told us that there are
19 a thousand drugs on patent in good standing in
20 Canada today. Is the number increasing of drugs
21 that have patents in good standing?

22 MR. MICHEL: I think it does. I think it does
23 and I would say that it does increase but I don't think
24 it does increase at a higher rate percentage than in
25 the industrial field.

26 MR. RICE: Now, who can apply to obtain a
27 chemical process for a drug? Any qualification on
28 the person applying?

29 MR. MICHEL: Yes. An inventor or his legal
30



1 representative. The inventor himself can apply or his
2 assignee or his successor in the title.

3 MR. RICE: What about a limited company,
4 incorporated, can it apply for a patent?

5 MR. MICHEL: Yes, they can apply. They can
6 apply but they must name the inventor of the applica-
7 tion and before the patent is granted they must satisfy
8 the office that they really own that invention. That
9 is, they must submit to us proof of contract of the
10 work or assignment.

11 MR. RICE: In their application to obtain
12 the process, what material must they submit to your
13 office? How do they identify their process?

14 MR. MICHEL: The patent application must con-
15 tain, in the first place, a petition, that is a prayer
16 to the document addressed to the Commissioner of
17 Patents saying that I, such and so or we, such and such
18 company make an application for a patent for a new
19 invention entitled such and such, which invention has
20 been made by Mr. So-and-so and that so far as we know
21 the subject matter of this invention has not been known
22 or used by others for more than two years.

23 If they want to take advantage of what we
24 call international agreements, they have to state that,
25 and then they must follow with an explanation, what
26 we call a specification which is an explanation of
27 the invention. That explanation does not always --
28 sometimes we do not require it. Sometimes we have to
29 ask for it, a statement of the trend or what was known
30



1 before along the same lines, and then the advantages
2 and disadvantages of that, and then a statement, a broad
3 statement of their own invention accompanied by
4 advantages that they find in their own invention, and
5 then they go on and describe their process in
6 detail, how they make the product and how they use it
7 and they must -- before you get a patent, you must
8 state the utility. If the utility is not mentioned in
9 the patent application, we have to refuse them and if
10 we miss, the Court would declare this patent invalid.
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1 It is not in every application. If you invent a
2 nut or bolt you don't have to say what is useful to
3 be put in the bolt. In chemical processes you say what
4 the chemical is good for, and you end up with a resume,
5 what we call a set of claims, a certain number of
6 paragraphs in which the inventor, the applicant,
7 claims what he thinks is new and what he thinks his
8 protection should be. He has to make a resume, and
9 in the description he can say anything, provided it is
10 true, and if there is something that is not true and
11 we do find it, it would be too bad for him later in
12 court. But he must put that in a few paragraphs,
13 stating what he regards as new and what he wants to
14 protect. Naturally every applicant will try to
15 cover the moon, so we have to look into that and
16 bring him down to size.

17 MR. RICE: Having regard to medicines
18 and drugs, this identifying process would be setting
19 out the process by which the drugs are manufactured.

20 MR. MICHEL: Yes, the substances, the
21 parent substances which are used in the process and
22 the different conditions under which the reaction
23 is conducted. You can put two substances together and
24 if you don't have the right conditions you will not
25 get the right result; you will get nothing or some
26 other result.

27 MR. RICE: Patents are usually granted in
28 name. Is that a process which has a name fixture?

29 MR. MICHEL: Yes, there is always a tag on
30 inventions; we have a title.



1 MR. RICE: Now, who selects that title?

2 MR. MICHEL: The title must be originally
3 presented to us, and it must appear in that first
4 document which we call a petition, a prayer to the
5 Commission, and if that does not satisfy the Patent
6 Examiner, then the Patent Examiner has the right to
7 ask for a corrected tag. When I sign patents
8 every week -- I sign 430 every week now -- and I am
9 not satisfied with the tag, you can change it yourself.
10 By that time it is usually correct.

11 MR. RICE: When you decide on the title,
12 whether it should be altered or not, having in mind
13 medicines and drugs, do you consult any pharmaceutical
14 society, pharmacopeias?

15 MR. MICHEL: No, it is not necessary. It
16 is not a title which gives protection anyway, and it
17 has never been proved to us that anyone has tried
18 to be funny with the title. Of course, it is not
19 a fancy title. We have nothing to do in the Patent
20 Office with trade names, either as title or in explana-
21 tion. It must be a chemical name, a real chemical
22 name, or the name which has become accepted by the trade,
23 and it is not protected by a trademark. We get this
24 list, this bulletin which is called World Health Organ-
25 ization, attached to UNESCO.

26 MR. RICE: Are there any requirements for
27 this title or name? What do you look for in the title
28 when you consider whether it is sufficient or not?

29 MR. MICHEL: The title to us is not very
30 important. The Patent Examiner -- if you will read the



1 process for making sulphathiazole -- he looks at the
2 thing there in the explanation and the claims and
3 everything, and if he finds this patent application
4 is correct, all right, but if he had a title "Chemical
5 Process" -- I don't know how many times I have found
6 chemical process for synthetic resin, and that is
7 a medicine.

8 MR. RICE: What about trade names? Is
9 that connected with your office in any way?

10 MR. MICHEL: Trademark comes under the
11 Secretary also but not directly under me. Many years
12 ago, about 30, 25 years ago, the Commissioner of
13 Patents was also responsible for trademarks, but since
14 1934, 1935 I believe the responsibility for the trade-
15 marks and the registration of trademarks has fallen
16 on the Registrar of Trademarks -- although I open
17 up his mail and take his money; we have a common
18 accountant. Mr. McCaffrey is the Registrar of Trade-
19 marks.

20 MR. RICE: I want to try to tie in this
21 application of registering a chemical process. A
22 brand name would be registered as a chemical process,
23 would it?

24 MR. MICHEL: Yes. After they start to
25 commercialize a drug they usually want to give it a
26 name, and they apply to the registrar's office for a
27 name. It has nothing to do with the Patent Office,
28 and if they do that we just throw it out or we make
29 them put this trade name in little brackets there and
30 identify the chemical formula, because the trade name



1 -- you take a trademark which is not restricted to the
2 chemical composition. If you buy Pepsodent Toothpaste
3 today, it is certainly quite different from the Pepsodent
4 you were buying ten years ago.

5 THE CHAIRMAN: And you cannot identify in
6 a specific fashion a name with the content?

7 MR. MICHEL: By the trade name?

8 THE CHAIRMAN: Yes.

9 MR. MICHEL: In most cases, no, especially
10 in connection with mixtures; and when it comes to
11 the new antibiotics, then there are several trade names
12 coming from several sources. If the substance is
13 pure, then it could be identified to a certain extent.
14 The manufacturer today or next week or next month or
15 next year may find that what he is selling today under
16 a trade name would be better if he added something to
17 it, and he would keep on the same name. It might be
18 of a better composition.

19 THE CHAIRMAN: Having in mind, Mr. Rice,
20 Mr. Michel's convenience and comfort, would this be
21 an appropriate time to have five minutes out, and I
22 would suggest that I have in mind that we are hoping
23 that we would be able to tell Mr. Michel that the work
24 could be done by noon.

25 MR. MICHEL; I am available all day.

26 THE CHAIRMAN: I think five minutes would be
27 desirable.

28

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2 --- On resuming after recess

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4 MR. RICE: Mr. Michel, just before recess
5 I believe we exhausted the title or name aspect of
6 the patent trademark. When the applicant applies
7 to register a chemical process for a drug or medicine,
8 is there any contest? Is there ever any contest
9 between an applicant and someone else who has a
10 chemical process very similar to that? How are
11 those contests resolved?

12 MR. MICHEL: We have, sir, in the Act
13 a procedure to determine who is first. The patent
14 system in Canada is to grant the patent to the first
15 inventor. In some countries they have first come
16 first served. The first applicant who gets the
17 patent. In Canada and the United States we grant
18 the patent to the first inventor so that when we have
19 applications in the Patent Office covering the same
20 invention, whether it is a process or a product, when
21 two or more applications cover the same invention,
22 we institute what we call "conflict proceedings".

23 That is described in Section 45 of the
24 Patent Act. In dealing with these applications which
25 are covering the same invention, we examine these
26 applications up to the point where we find some of
27 them or all of them allowable. In the course of
28 examination we may reject some of them because they
29 may not amount to patentable inventions, or they may
30 be anticipated by some prior one. But those



1
2 applications that survive examination, we prosecute
3 them right to the point where we would advise the
4 applicant that he can have a patent. Then we write
5 to both, to all parties that are claiming the same
6 invention, and we say there is someone in the office
7 -- we don't name them -- we don't name the other
8 party, but there is someone in the office who is
9 claiming the same invention as you do, and normally
10 we take some of the claims from one application and
11 give them to the other party. And we cross the claim
12 like that, and tell them do you want to proceed with
13 that.

14 If they say yes, we put these claims in
15 their application, and then once again we tell all
16 the parties do you know of any objection by way of
17 prior knowledge? Have you any reason to believe
18 that this is not patentable? So naturally, when
19 all the parties are asking for a patent, it doesn't
20 happen very often that someone will come up and give
21 us some reference, but sometimes it does happen.
22 These investigators, they know not only what they are
23 doing, but they are pretty well aware of what their
24 competitors are doing.

25 THE CHAIRMAN: In effect now you do have
26 a hearing?

27 MR. MICHEL: It is a hearing before the
28 Office. It is all in writing. The prosecution in
29 writing.



1
2 MR. MICHEL: So that sometimes the
3 patent agent, or company representative will come to
4 discuss a point with the Examiner but then when he
5 leaves, goes back home, he puts it in writing, you
6 see.

7 THE CHAIRMAN: Mr. Rice, would you
8 direct your examination in the avenue of the restrictive
9 effects of a patent, if any?

10 MR. RICE: Yes, I was coming to that
11 next, Mr. Chairman.

12 Now the effect of a patent, you have
13 already told the Committee, that these are negative
14 rights. That is the way you described the patent
15 I believe?

16 MR. MICHEL: Yes, that is the way I did
17 describe it. The right to exclude others from using
18 your invention.

19 MR. RICE: Now these rights, can they
20 be assigned in whole or in part?

21 MR. MICHEL: Yes, they can be assigned
22 in whole or in part.

23 MR. RICE: And what is the process?
24 How do they operate?

25 MR. MICHEL: Just an ordinary contract.
26 A company may sell a patent to another company for
27 consideration. They may have all kinds of conditions
28 into it. That is their own affairs. Sometimes
29 they do submit that document to us. Some other times
30



1
2 they just say for the consideration of one dollar
3 I sell all my rights and interest in that patent,
4 and they assign it, and then we have -- you will
5 find in one of the forms here a form for an assignment.

6 Provided we have the signature, the
7 formal signature of the former owner conveying his
8 right to the other party, we register it, and then
9 the title, the ownership of the patent goes over to
10 the other party. That is assignments.

11 Also there is the case of licensing. An
12 owner can license a patent and he can record his
13 licence, the licence can be recorded in the patent
14 office. That does not change the title. The licence
15 does not change the title.

16 MR. RICE: Well the assignment then
17 does change the title to the patent?

18 MR. MICHEL: Yes, changes the ownership,
19 definitely.

20 MR. RICE: And then if a party wants
21 merely to give another person the use of the permit,
22 the use of the process, then he issues a licence?

23 MR. MICHE: Yes, a licence.

24 MR. RICE: The assignment, first of all,
25 is a matter of contract between the two parties, is
26 it?

27 MR. MICHEL: That is right.

28 MR. RICE: And the office has no
29 requirements as to the contents of that contract?
30



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2 MR. MICHEL: No, it hasn't provided
3 it is a straight contract.

4 MR. RICE: Does that contract have to
5 be filed in your office?

6 MR. MICHEL: It is not compulsory but
7 if the acquirer of the patent does not record his
8 contract in the office, he has no recourse against
9 a third party. That is, if the first owner of the
10 patent sells the patent to you, and he is not quite
11 honest, he turns around and sells it to another, a
12 third party, and you have no record in the office of
13 your assignment, then it does not count on you. It
14 is invalid. You have recourse in bad faith. That
15 is all. That is Section 53 (4) of the Patent Act.

16 MR. RICE: With regard to a licence, is
17 there any form that the Department requires for the
18 licence? Where is it registered?

19 MR. MICHEL: No, the Patent Act authorized
20 the Commissioner and the Patent Office to deal with
21 patent applications and grant orders. After that,
22 we have nothing to do with it.

23 MR. RICE: So the licence is also a
24 matter of contract between two parties?

25 MR. MICHE: Yes, it is. An ordinary
26 licence.

27 MR. RICE: And the consideration for that
28 licence, there is no control over the consideration
29 for that licence?
30



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2 MR. MICHEL: No, we have no control
3 over that.

4 MR. RICE: Or the royalties to be paid
5 under the licence?

6 MR. MICHEL: No.

7 MR. RICE: Dealing with the question of
8 licence, you have mentioned before, I believe to a
9 question Mr. Wren put to you, about the limited licence
10 that the Commissioner has the power to invoke, and I
11 believe you very seldom invoke that power. You stated
12 it has not been used very extensively?

13 MR. MICHEL: That is exactly the point
14 that I have forgotten to make out. I told you a while
15 ago that since the beginning, since 1950 -- there
16 were none before my time -- there have been fourteen
17 applications for licence under Section 41 (3) of the
18 Patent Act for food and drugs.

19 This is a very very small number, and as
20 a matter of fact I only granted four, I believe, and
21 there are some of them amongst the fourteen where the
22 parties have got together. In many cases, an
23 applicant will go to a patentee and ask for a licence.
24 The patentee in the first place will say no, but then
25 the applicant comes to the Patent Office and he finds
26 out that he is under the same condition of so and so,
27 or under his own condition in which he was in a former
28 application where I granted the licence and he turns
29 around and he grants a licence.
30



1
2 In some cases I go to a hearing in
3 connection with the application for licence and then
4 I grant a licence if I do not see any reasons to the
5 contrary. That is putting the onus on the patentee
6 to show me any reason to the contrary. The applicant
7 just comes to me and says in the hearing -- if I call
8 for a hearing, I don't have to call for a hearing --
9 as a matter of fact, I granted two last spring without
10 a hearing because I knew all the conditions, both
11 parties but if I do not know all and if I feel that
12 there is something I ought to know, and I don't know,
13 or I think I may find some useful information by
14 calling for a hearing, I do call for such a hearing
15 and then the parties come before me. The applicant
16 tells me his qualifications and his willingness to
17 manufacture and it is up to the other party to tell
18 me why there should be no licence. So far I have
19 refused only one after a hearing. In many cases
20 after a hearing, and if I declare there should be a
21 licence, I then leave it at that for the time being.
22 I give them two or three months, usually ninety days
23 to come up with an agreement between themselves. I
24 always feel it is better for two people to deal
25 together willingly than to have a licence pushed down
26 their throat by the Commissioner's order.

27 MR. WREN: That was the point I was
28 getting at, Mr. Michel, before. Mr. Rice, excuse me
29 for a moment.. When you grant -- when you exercise
30



1
2 your authority in granting that licence, or perhaps
3 modifying it by allowing them to come to an agreement
4 among themselves, can the person who is assigned to
5 the rights, dictate the price?

6 MR. MICHEL: When they dictate that point,
7 well, he states his price. If the applicant agrees
8 to that price, fine. The applicant finds that the
9 price is too high so he says I don't want any of that,
10 let the Commissioner do it, and then I set the price.

11 MR. WREN: Leading up to that point, when
12 you make the decision, you are the sole maker of the
13 decision, do you suggest or imply in any way what the
14 price would be?

15 MR. MICHEL: In most cases I do. In my
16 decision, you see in my order for granting a licence
17 I have a power, and then I issue -- it is this order
18 for the granting or refusal of the application. If
19 it is an order for the granting of a licence, I usually
20 say licence royalty should be such and such, five,
21 ten, fifteen per cent, whatever I think is right after
22 consultation with them at the hearing, you see, and
23 then the other conditions of the licence, I leave them
24 open for them to get together. If they don't, then ---

25 MR. WREN: One final question on that
26 particular subject. You say that you granted four
27 or five out of fourteen since 1950?

28 MR. MICHEL: Yes.

29 MR. WREN: How many of the five were in
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1
2 the antibiotic field? Were most of them? Some of
3 them?

4 MR. MICHEL: A few of them. I think
5 were two in the antibiotic.

6 MR. WREN: All right then, in the nine
7 rejected or you didn't issue an order on, shall we
8 say, how many of those were in the antibiotic field?

9 MR. MICHEL: I think it was two. I think
10 there were two. I rejected one personally. The
11 others fell by the board, or they made arrangements
12 between themselves or they were abandoned. They were
13 made by firms that were only distributors.

14 MR. WREN: Were any of them any common-
15 place drug items such as aspirin tablets or similar
16 products? Something that is quite common?

17 MR. MICHEL: Unfortunately, I am not a
18 pharmacist, and as I told you we are dealing with
19 chemical names here and I was too short a time to take
20 a look at the patent to find out what they were good
21 for. What I have here is chemical names. One is
22 sulfathiazole, which is one of the sulfa drugs,
23 synthetic, sulfanilamide, that is another one, that is
24 also synthetic. Ether, it is not an antibiotic.
25 Mercurated allylurea diuretics.
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2 MR. WREN: This is a fair question.
3 Say so if it isn't. In any of those applications
4 did you notice, in the discussion of price, any marked
5 difference between the original cost and what the
6 applicant proposed to charge for the drug?

7 MR. MICHEL: I don't quite get your
8 question.

9 MR. WREN: Well in the case where a
10 person applied to you for a licence to issue these
11 products, to manufacture these products, in the
12 detail of the application, or in any of the hearings
13 was there any marked difference between the price he
14 proposed to sell at, and the price the original
15 patentee was charging?

16 MR. MICHEL: Yes.

17 MR. WREN: Any marked difference?

18 MR. MICHEL: In some cases yes, quite a
19 marked difference.

20 MR. BOYER: I take it in some of these
21 applications had to do with particular process which
22 had been patented, and which the applicant wished to
23 use in connection with the use in another form, if
24 he had to use, say, one particular process combined
25 with other processes, is that correct?

26 MR. MICHEL: Yes. There were several
27 applications which involved certain number of patents.
28 I know that there was one at one time, an application
29 -- it isn't in this list here, the applicant wanted
30



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2 a licence for a whole thing, involved thirteen patents,
3 and the application in the first place was informal
4 so I took the position, when I wrote back to him, to
5 tell him to put his application in formal order that
6 he was asking for a licence for the whole field, that
7 he should make up his mind because if he wanted a
8 licence for the whole field, involving thirteen
9 patents, the royalty will have to be higher than if
10 he selected amongst these patents the process or
11 processes which he wanted to use, you see, and not ask
12 for a licence for a process that he would never use.
13 He abandoned that application completely and he came
14 back with four I believe.

15 THE CHAIRMAN: It is possible, Mr. Michel,
16 that some of the licensing arrangements could be done
17 by consent and not go through your office?

18 MR. MICHEL: Yes, it is. That is the
19 point I had forgotten to make out. You see, when I
20 say fourteen applications in all this time, that is
21 very, very, few applications. I think that Section 41
22 (3) has had a very salutary effect on the industry.
23 I believe so, because they are faced with that, and
24 furthermore, we are so close to the United States --
25 as you understand, 73 per cent, every year, 70 to 73
26 per cent of our patents originate from inventions made
27 in the United States, so that the proportion for drugs
28 is at least 70 to 75 per cent also, and as you know,
29 a whole lot of the United States pharmaceutical
30



1
2 manufacturers have branches in Toronto, or have
3 affiliates in Canada.

4 MR. WREN: I take it if a Canadian
5 manufacturer has the qualifications to produce that
6 drug cheaper than another, than the patentee, there is
7 nothing to bar him from making an application
8 personally.

9 MR. MICHEL: Not only that. He doesn't
10 have to prove to me he can make it cheaper. He can
11 prove to me he can make it and make it good, and that
12 is all. The question of price has been settled by
13 the courts in England.

14 MR. LAVERGNE: Mr. Chairman, just one
15 question I want to ask. Mr. Wren was pursuing this
16 I wish to go a little further. I think one of your
17 questions was to the effect, Mr. Wren, that if an
18 applicant made application for a licence, does he
19 state in that application what he proposes to sell his
20 drug or product for?

21 MR. MICHEL: He doesn't have to. He
22 doesn't have to do it. Sometimes they do. In one or
23 two instances they have done so, but in most cases
24 they say they can sell it cheaper, and some cases they
25 don't say anything about it.

26 MR. LAVERGNE: What you are mainly
27 concerned with is the fact that they can produce the
28 drug?

29 MR. MICHEL: If they are equipped, if they
30



1
2 have financial means and the equipment to manufacturer.

3 MR. LAVERGNE: And the royalty will be
4 set by ---

5 MR. MICHEL: In this I have to do with
6 the Food and Drug -- you may say that I am not
7 concerned whether he is capable of manufacturing or
8 not. Now if I give a licence to a firm I know he has
9 not the knowledge or the equipment to make that drug,
10 Food and Drug will have trouble with him so might
11 just as well cut it down right there.

12 MR. WREN: There is nothing at all that
13 would allow a foreign manufacturer to dominate the
14 Canadian manufacturer if we had people who were
15 qualified to manufacture ?

16 THE CHAIRMAN: Now we are getting into
17 the question of International --

18 MR. WREN: No, what I am getting at, Mr.
19 Chairman, is that if a foreign manufacturer were
20 attempting to dominate our market with a certain
21 product, there would be nothing to prevent a Canadian
22 manufacturer, with qualifications, to enter that field
23 by application to you?

24 MR. MICHEL: That is right, sir, he could.

25 THE CHAIRMAN: Then the record Mr. Rice,
26 I think we should complete the record. Mr. Wren's
27 point is well taken but I think we should complete
28 the record with respect to the effect of international
29 patent law.
30



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2 MR. RICE: I was going to ask Mr. Michel
3 about that. I just wanted to bring out first, that
4 with this power of the Commissioner to interfere or
5 to set terms of the licensing, including the royalties
6 to be paid, or commissions to be paid, is that peculiar
7 to the drug business?

8 MR. MICHEL: In a sense, yes, it is
9 peculiar to Section 41 (3) to set the royalties.

10 MR. RICE: I mean, it applies to the drug
11 business and you do not have necessarily the same
12 thing in connection with licensing arrangements?

13 MR. MICHEL: No. Food and Drug have
14 this power. In other fields, in the synthetic fibre
15 fields, for instance, as the Chairman was mentioning
16 a while ago, if there has been abusive privilege by
17 not manufacturing in Canada or not supplying the demand
18 at a reasonable price, then upon hearing I can also
19 set the royalty.

20 MR. BOYER: There are some of these
21 applications based on price?

22 MR. MICHEL: These applications here based
23 on price?

24 MR. BOYER: That is to say I think the
25 section which you read to us this morning Section 41,
26 mentioned that the product shall be made available to
27 the public at a reasonable price.

28 MR. MICHEL: Lowest possible price.

29 MR. BOYER: Lowest possible price consistent
30



1
2 with his rewards?

3 MR. MICHEL: Yes. Some applicants have
4 paid, based on their application, they did not have
5 to. They would have mentioned that they were capable
6 of manufacturing and supplying to the public at a lower
7 price than the price charged by the patentee. They have
8 done that in some cases.

9 MR. RICE: And the fact that the manufacturer
10 can do that permits you to use your powers under this
11 section and give him licensing privileges?

12 MR. MICHEL: Yes.

13 MR. RICE: That licensing privilege extends
14 also to the ingredient of the product as well as the
15 whole product does it not? In other words, if a new
16 manufacturer wants to use a patent, or a patented drug
17 as part of a new product that he wants to develop, can
18 he apply to you for this if he cannot come to some
19 arrangement with the party that has the patent in good
20 standing? Can he apply to you for you to exercise
21 your rights to permit him to use that ingredient in
22 his product?

23
24 (Page 802 follows)
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2 MR. MICHEL: Yes, he can, in view of the
3 wording of Section 41, subsection 3, which is:

4 "In the case of any patent --"
5 no restriction there --

6 "-- for an invention intended for or
7 "capable of being used for the preparation of
8 "food or medicine."

9 So that anyone can come to him and ask for a licence
10 on any patent, even an industrial product which is
11 patented. He says, "I can take this product and I
12 want to make this product, to manufacture a medicine."
13 He has the right to give it to him then.

14 THE CHAIRMAN: One of the things that I do
15 not understand, and I do not like to name an example,
16 is what sort of principles apply to a licence? What
17 is it based on? Do they put a percentage on it, a
18 dollar an ounce, or so much a product, or so much
19 according to the volume, or what sort of principles
20 apply? Do you know anything about that?

21 MR. RICE: I don't, but I think Mr. Michel
22 might be able to explain that to the Committee, perhaps.
23 What do you take into consideration when you decide
24 on a royalty or commission that is to be paid?
25 What factors do you take into consideration?

26 MR. MICHEL: Naturally you can understand
27 in these circumstances I am pretty well on my own,
28 because I get very little co-operation from the
29 manufacturers.

30 THE CHAIRMAN: Nor from either party.



1
2 MR. MICHEL: So I usually base my recommenda-
3 tion on several things. I try to find out the
4 manufacturing costs, their manufacturing costs of the
5 drug, to get something fairly reasonable. One big
6 argument I always get is, "It may not cost us much to
7 manufacture these drugs once we get started, but we have
8 spent millions of dollars to arrive at that drug in
9 research and we must be compensated for it. Our
10 patent is only good for seventeen years, so that in
11 seventeen years it is only reasonable that we come into
12 our money."

13 So in setting the cost of the drug I try to
14 compensate the inventor for his research and I try to
15 strike a percentage usually based on the manufacturing
16 cost.

17 Section 41, subsection 3 says I shall make
18 the drug available at the lowest price to the public
19 consistent with giving to the inventor due reward for
20 his research leading to the invention.

21 MR. WREN: Are they compelled to reveal to you
22 the costs of their research?

23 MR. MICHEL: Yes, I can ask for this infor-
24 mation. According to Section 4 of the Patent Act,
25 I have all the powers that are or may be given by the
26 Inquiries Act to a Commissioner appointed under Part 2
27 thereof.

28 MR. WREN: So that you can put them under
29 oath.

30 MR. MICHEL: Oh yes, I put them under oath.



1 MR. WREN: You can obtain from him a state-
2 ment of the cost of the research.

3 MR. MICHEL: Yes.

4 MR. SUTTON: Is that the usual procedure?

5 MR. MICHEL: To a certain extent. The
6 witnesses at the hearing, both parties, submit oral
7 evidence and there are usually three or four on each
8 side. When I find the right person on the stand,
9 I try to get the information out of him. Sometimes he
10 does not even realize what is going on.

11 MR. FULLERTON: I would like to ask Mr.
12 Michel, have you any records as to what they derive
13 from the invention after they have spent money for
14 research of a specific drug.

15 Do they come back and say, "We have derived a
16 good profit from our investment on research, and we are
17 prepared to reduce our price."?

18 MR. MICHEL: I have no record of that, because
19 it would be very, very difficult. In the first place,
20 these drugs are not patented,--the patents are not
21 only in Canada. The invention is usually patented in
22 a dozen countries. I would say a big manufacturer
23 would probably take patents in the United States and
24 Canada and in Western Europe, and there would probably
25 be 12 to 15 patents.

26 Naturally they derive the benefits from all
27 these countries and we do not do anything about that.
28 Furthermore, before they arrive at the useful product,
29 they may have failed on dozens or hundreds of tries
30



1 and probably one product out of 100 will succeed. It
2 may have cost relatively little money to make research
3 on this one successful drug, and they may have failed
4 in all others. It is physically impossible for me or
5 anyone else to take the whole operation of that
6 pharmaceutical industry or pharmaceutical house into
7 consideration.

8 Maybe this particular drug has only required
9 a little money to be spent on it, but they may have
10 spent considerable money investigating other drugs,
11 and as far as they are concerned they are putting the
12 whole thing into a pool.

13 I think it is logical to think these people
14 could put all their expenses for research together
15 and then try and balance them with the revenue from
16 their successful products that they have developed.
17 So that it is very, very difficult to point out --
18 in fact it may be physically impossible to point out --
19 what revenue or what reward they receive.

20 THE CHAIRMAN: That is the Gagnon principle
21 that is probably available to you if you do have the
22 consent agreements on their licensing arrangements.

23 MR. MICHEL: I don't quite get your
24 question.

25 THE CHAIRMAN: To assist you in your arbitrary
26 powers, you probably have assistance of the
27 percentage or arrangements which have been arrived at
28 by consent.

29 MR. MICHEL: In some cases I have. I usually
30



1 find them a bit too hard, the consent arrangements.

2 It is a good guide when I can get hold of them.

3 MR. FULLERTON: What I was trying to get at
4 was, they come to you with the facts and the figures
5 of the cost of research, to produce this product.
6 Do they ever come back with the profit they derive
7 even after they have been paid off well for the research?

8 THE CHAIRMAN: I wonder if that is not like
9 saying that the fellow who owns a parking lot, having
10 got his money back in two years, should let everybody
11 park for nothing.

12 Now we are into the matter of real philosophy,
13 Mr. Fullerton. Let us face it, we are up to that now,
14 aren't we?

15 MR. RICE: Could you tell us, Mr. Michel --

16 THE CHAIRMAN: Just a minute, Mr. Rice, Mr.
17 Fullerton and I might have something to talk about
18 here.

19 That is something, Mr. Fullerton, that goes
20 pretty much to the roots of everything, doesn't it?

21 If you get an automobile that you can run as
22 a taxi-cab for 100,000 miles, that is fine and nice.
23 It is running well. You are going to charge straight
24 fare for it. You are not going to let a passenger say,
25 "This thing has driven 100,000 miles. I want to ride
26 for nothing."

27 MR. WREN: They do in the Metro Licensing
28 Board.

29 MR. FULLERTON: They license on the basis
30



1 of selling this patented drug, on the assumption that
2 they are going to sell one million, but it turns out
3 they sell five million.

4 THE CHAIRMAN: What does that do? That is
5 the point. Does that do something or not?

6 MR. FULLERTON: They have figured the cost
7 of research according to one million, but they sell
8 five million. That is what I am trying to get at
9 about the cost of drugs.

10 THE CHAIRMAN: What is wrong with that?

11 MR. FULLERTON: Why couldn't they reduce the
12 retail price?

13 THE CHAIRMAN: That is the point that we are
14 kicking around here. He may have no control over it.

15 MR. FULLERTON: My suggestion is, when you
16 are dealing with this, would it be well to find out
17 what they derive from the sale of some of these
18 patented drugs toward research of former drugs which
19 are being used?

20 MR. MICHEL: I try to get at that, but it is
21 very, very difficult.

22 MR. FULLERTON: They just give you one side
23 of the picture and forget about the other side.

24 MR. MICHEL: I try and get as much of the
25 other side as I can.

26 MR. FULLERTON: I am trying to get at the
27 fact that they base their retail price on a certain
28 amount and they occasionally sell more, but they forget
29 about that. I am wondering if the cost should not be
30



1 based on their net profit.

2 MR. MICHEL: That can happen. I would say
3 this, that in my experience the useful life of these
4 drugs is usually very short. In our times with so
5 many institutions, public institutions, and so many
6 competitors in the field making research, it does not
7 take very long before one drug becomes obsolete and is
8 superseded by another one. Some of the drugs last for
9 a certain time and normally when the price is coming
10 down, in view of the fact that nobody states where he
11 is in that or any other manufacturing field, he would
12 never be able to sustain himself. He has to progress.
13 He is always looking for better ways and methods of
14 making the product so that his manufacturing costs
15 are lower.

16 In the case of drugs that last for a cer-
17 tain number of years, the price usually comes down.
18 We talk about the high price, and it may be a per-
19 sonal opinion, but I have the opinion that drugs
20 that are very, very high in price are not expected
21 to last very long.

22 THE CHAIRMAN: I think in fairness to the
23 witness it might be proper to say that as I under-
24 stand the situation the authority of the Commissioner
25 of Patents is defined by the Patent Act. He makes a
26 decision at a certain point when someone applies for
27 a licence to manufacture a product which is covered
28 by a patent owned by someone else.

29 The Commissioner's jurisdiction is to see
30



1 that there is no monopoly or unreasonable confinement
2 of the use of that patent. In laymen's language, is
3 this something close to the fact?

4 MR. MICHEL: Yes, it is close to the fact.

5 THE CHAIRMAN: However, the economic or
6 mathematical results of this, are they of concern to
7 you?

8 MR. MICHEL: Well, I am concerned when I try
9 to set my royalties, the royalty percentage.

10 THE CHAIRMAN: You have to set it at a cer-
11 tain time when the application is made. You don't have
12 to review your own decisions, or do you?

13 MR. MICHEL: No, once I have set my royalty,
14 it is appealable to the Court, appealable to the
15 Exchequer Court.

16 THE CHAIRMAN: They have the right of appeal
17 to the Court?

18 MR. MICHEL: Yes, they have the right of
19 appeal to the Exchequer Court.

20 THE CHAIRMAN: But you don't go back five
21 years later and say, "I want to open this file".

22 MR. MICHEL: No, not on my own.

23 THE CHAIRMAN: Let us get the record straight.
24 Your duty, as I understand it, under the Act is to
25 see that there is no monopolistic use of a patent under
26 the Act.

27 MR. MICHEL: Correct.

28 THE CHAIRMAN: And that some other applicant
29 can use and benefit from it upon payment of a fee to
30



1 the original inventor or his assignee.

2 MR. MICHEL: That is right. That is my
3 duty.

4 THE CHAIRMAN: Is that the law or not?

5 MR. MICHEL: That is the law.

6 THE CHAIRMAN: Is that the objective?

7 Let us get back now, Mr. Rice, to the objective of
8 the Act? The objective of this section of the Act is
9 to see that no holder of a patent -- and I hate to
10 impose my language on you, and if I am wrong, correct
11 me -- that the holder of a patent cannot sit on it.

12 MR. MICHEL: That is right. He cannot sit
13 on it.

14 THE CHAIRMAN: Contrary to the public interest.
15 Is that the intention?

16 MR. MICHEL: That is right. That is the
17 spirit of the Act.



1
2 MR. WREN: Then, Mr. Chairman just to clear
3 my mind on one point, simply on the application of
4 the Act, you said earlier that a person, an applicant,
5 who obtains a patent must, within three years, commence
6 manufacture of that product in Canada to protect his
7 rights.

8 MR. MICHEL: Yes. That is a general principle
9 of the Patent Act; it applies to everything, all
10 industrial products, machinery and everything. But
11 when it comes to drugs, this three-year limitation
12 is gone. There is a special licensing provision,
13 insofar as food and drugs are concerned. It is
14 contained Section 41(3). Say a patent came out today,
15 on Tuesday for a drug. If you are a drug manufacturer
16 and you want to make it, you can come tomorrow and
17 ask for a license.

18 MR. WREN: If an American manufacturer
19 manufactures a certain drug, unless there is an
20 application from a Canadian manufacturer there is no onus
21 on him to commence manufacture of that drug in Canada?

22 MR. MICHEL: Within three years, no.

23 MR. WREN: He can hold it for 17 years?

24 MR. MICHEL: No, he can have it for three
25 years, but in three years, whether it is a drug or
26 not, he can be taken up under that section for failing
27 to manufacture. But he can apply right away.

28 MR. BOYER: Following up the remarks about
29 the research costs which are revealed to the Commissioner,
30 you were asked if you were given any information as to



1 the profits, and so forth. I was going to ask you
2 about an angle there, if other firms might not apply
3 to have a licence to manufacture on the terms that
4 the price was too high. I say, Mr. Chairman, that
5 I felt surprised that the number of such applications
6 has been so small.

7
8 MR. MICHEL: The Act is there, it is available
9 to the Canadian manufacturer, and there have been
10 very few applications, as I have said. I think there
11 have been a great number of voluntary licences granted
12 to Canadian manufacturers on the grounds of those
13 provisions.

14 MR. BRYDEN: What court procedure could
15 be followed if anyone challenged your decisions?

16 MR. MICHEL: It goes to the Exchequer Court.

17 MR. BRYDEN: And then I presume it would go
18 to the Supreme Court?

19 MR. MICHEL: It can go to the Supreme Court,
20 yes.

21 MR. RICE: Can you tell the Commission how
22 you relate these royalties. Do you relate them to
23 volume? How is it set out?

24 MR. MICHEL: The royalty is usually based on
25 a percentage of the manufacturing cost, but more
26 often it is the selling cost to the retailer. Normally
27 these drugs are made in bulk, the crude drug is
28 made and it has got to be packaged or pelleted or
29 mixed up with something else, with filler, and when
30 you come to that price from the crude drug, when you



1
2 come to the finished product in the store, it is
3 away up. I usually base my licence on the sale price,
4 the selling price of the crude product to the person
5 who will make it into a finished product, without
6 making any change in the product itself. Most of
7 them must be taken in a very, very small dose. This
8 packaging business is outside of my province. I
9 don't think it would be fair to base the royalty on
10 the price of the finished product as sold, for instance,
11 to the druggist.

12 MR. RICE: Is there a big difference between
13 the price of the product that he purchases and the
14 price he sells to the druggist?

15 MR. MICHEL: The big mark-up is there.

16 MR. RICE: The chairman asked you about
17 international conventions. Is there any international
18 conventions in relation to drugs?

19 MR. MICHEL: No, there is no convention in
20 relation to drugs or licensing drugs specifically.
21 There is one international convention on patents,
22 that covers patents, trademarks and industrial designs.
23 It has nothing to do with licensing drugs at all.
24 The purpose of the convention is to give a priority
25 right of an applicant from one country into another
26 country of convention. There are 44 countries, I
27 think, most of the biggest countries in the world.
28 I think there are about 175 patent systems throughout
29 the world, but most of them are very skimpy. There
30 are about 50 countries have very good patent systems,



1 and 44 of them belong to this international convention,
2 which we call the Paris Union, which was formed in Paris
3 in 1883, and it has been subsequently revised a
4 couple of times, the second last time in London in
5 1934 and again in Lisbon. There was a Canadian delegation
6 over there. But this convention is mostly for foreigners
7 applying in other countries. Frankly, it is no good
8 for foreigners in Canada, but it is good for people
9 outside, on account of the peculiarity of our Act.
10 In Canada you have two years' grace and you can disclose
11 your invention and within two years apply to the Patent
12 Office and still get it. But in most European countries
13 you must apply to the convention before you disclose
14 your invention. If you disclose your invention you
15 are out of luck. When we apply in another country
16 the application in the other country is effective
17 from the first application which is made in Canada.

18 THE CHAIRMAN: What about the reciprocal
19 clauses of that convention? Are there any? Does
20 a patent in France have an effect in Canada?

21 MR.MICHEL: No, it has effect where it is
22 taken, and that is all.

23 THE CHAIRMAN: This is somewhat different
24 from copyright.

25 MR.MICHEL: Yes. Copyright, according to
26 the Union, is where you produce a work, whether music
27 or a book or artistic work, and if you a member of
28 the International Union, of which there are 47 countries
29 are members, you get automatic protection from the
30



1 other countries.

2 THE CHAIRMAN: But if one of the members
3 of the committee this afternoon were to invent a
4 new process to come within the terms of your Act,
5 it would then be necessary to file application in any
6 country in which we wish to sell our merchandise or
7 to manufacture.

8 MR. MICHEL: Definitely, yes. The question
9 of an international patent has been pushed around
10 for the last 50 years, and the more we push it the
11 farther it gets away. No country wants to accept
12 a patent from another country. We have our own
13 peculiarity of laws, we have our own way of living,
14 We are getting somewhere with international research,
15 which may come about. There is now in Europe a
16 Bureau, in the Hague, which makes international research,
17 and there are about five countries make themselves
18 available in the research. As far as I am concerned,
19 I agree with it. Whether we could use it in Canada,
20 being so far, there might be difficulty.

21 THE CHAIRMAN: Let me ask you this, Mr.
22 Michel. Within the restrictive scope of international
23 co-operation on the subject of drug patents, are there
24 any major drug-producing countries which don't even
25 abide by what we have got, by what co-operation presently
26 exists, and I would say my question is directed to
27 foreign manufactured drugs, as in Italy.

28 MR. MICHEL: Yes.

29 THE CHAIRMAN: Is Italy bound by this convention?
30



1
2 MR. MICHEL: : Italy is bound by the
3 Convention, but the Convention doesn't tell you what
4 you have to protect, what your law should be. So
5 that in Italy, as you say, Italy does not recognize
6 this system on drugs or even processes. Even processors.

7 THE CHAIRMAN: What is the effect of
8 Italy's position on our use and consumption of drugs
9 in Canada?

10 MR. MICHEL: That would take an economist
11 probably to answer the question. They can make at
12 home everything they want, and then if the law, the
13 Canadian law or Canadian tariff allows exporting from
14 Italy into Canada of that drug, and there is no
15 Canadian patent, then we get the drug in here.

16 THE CHAIRMAN: That means if a man in
17 Italy, and forgive me for mentioning any country by
18 name, but I have to take an example ---

19 MR. MICHEL: Sure, sure.

20 THE CHAIRMAN: If you were to analyze
21 a specific drug and get the ingredients and composition
22 of it, you could go to Italy and manufacture it?

23 MR. MICHEL: That is my understanding.

24 THE CHAIRMAN: And if you merchandise
25 it in Canada through whatever agencies you chose,
26 you would only be subject to the tariff?

27 MR. BRYDEN: You have to demonstrate
28 you are not infringing on a Canadian Patent?

29 MR. MICHEL: Yes, that is right.
30



1
2 MR. BRYDEN: The onus is on the distributor
3 to prove that the product is not manufactured by some
4 process that is already under patent in Canada; which
5 I think would be a fair restriction.

6 THE CHAIRMAN: I was going to say I didn't
7 think there was any restriction at all, because by
8 the time anybody caught up with him he would have
9 distributed \$500,000.00 worth of the product.

10 MR. WHITE : The onus is on the distributor.

11 MR. BRYDEN: I assume there would be
12 somebody in there, if someone were starting to
13 manufacture right here in violation of the patent,
14 I presume he has to be challenged before anything
15 happens?

16 MR. MICHEL: He would probably be
17 challenged by the holder of the patent in Canada. If
18 the holder of the patent does not challenge him, he
19 is going to go Scot free.

20 THE CHAIRMAN: If there is no challenge?

21 MR. MICHEL: Yes, but if he is challenged,
22 he is subject to Section 41 (2) of the Act.

23 MR. FULLERTON: If a drug is manufactured
24 and patented in Italy, and patented in Canada and the
25 United States, if the parent company is in Italy, would
26 they necessarily have to start manufacturing in Canada?

27 MR. MICHEL: Oh yes, they would. In the
28 first place, they would be subject to the general
29 provisions of the Patent Act: They would have to
30



1
2 manufacture within three years. Otherwise, if it is
3 a drug, three years is wiped out. A Canadian
4 manufacturer can ask for a licence to manufacture
5 in Canada. By the way, licences are only granted
6 for manufacture in Canada.

7 THE CHAIRMAN: We seem to be interrupting
8 you, Mr. Rice.

9 MR. RICE: That is quite all right.
10 To sum up, the International Convention would appear
11 to have little effect on the drug business in Canada.

12 MR. MICHEL: No.

13 MR. RICE: If the drug manufacturer
14 wants to improve on his patent, does he have to apply
15 for another patent to have it altered?

16 MR. MICHEL: He can apply for an
17 improved patent, or if he has found a completely
18 different process -- it may not be an improvement on
19 the first process; it might be a completely different
20 process, and that happens all the time. It happens
21 all the time. There are some drugs, there are known
22 drugs here with probably about twenty different patents
23 on it. Process patents.

24 MR. RICE: Referring to this term of
25 yours, you say the patent was good for seventeen years?

26 MR. MICHEL: Yes, seventeen years, sir.

27 MR. RICE: And is it renewable within
28 that time?

29 MR. MICHEL: No, no patent can be renewed
30



1
2 in Canada.

3 MR. RICE: Would the manufacturer, by
4 invoking this provision for improvement, thereby
5 renew his patent towards the end of the seventeen
6 years?

7 MR. MICHEL: At the end of the seventeen
8 years in each patent that is the end of that process.
9 Anyone can use it without any permission. It is in
10 the public domain.

11 If a manufacturer has a basic process to
12 make a certain product, and five years later it is
13 patented -- today it will run for seventeen years
14 -- and five years from now he finds an improved
15 method, not a new method, but improves his method
16 and he patents it, it amounts to a new invention and
17 he patents it, at the end of the first seventeen years
18 anybody can use the first method, and he will not
19 be bothered, but the patentee still will have another
20 five years to run on his improved patent. He can't
21 prevent anyone from using the basic process after
22 it has expired.

23 MR. RICE: Does your department, when it
24 grants a patent to a manufacturer impose any terms
25 or requirements on the manufacturer to give instructions
26 when he markets a product as to its dosage or anything
27 like that?

28 MR. MICHEL: No, this is not within the
29 Act. We just find out if there is -- insofar as
30



1
2 we are concerned, we are not concerned with drugs.

3 We are concerned with the chemical
4 compound, the process of making a chemical compound.
5 If that process works satisfactorily and if it is
6 invented, it amounts to an invention -- it is more
7 than the ordinary thing that the man conversant with
8 that can do; if it has some kind of ingenuity in it
9 to make a chemical compound, that is all we are
10 entitled to look at.

11 He must at the same time give the ingredients
12 of his product; he gives us the use of his product,
13 and we have no more control.

14 MR. RICE: What provisions have the
15 Department got to test a chemical process to ensure
16 that it does do what the applicant says it will do,
17 and so on? Or are there any tests or checks made
18 on it?

19 MR. MICHEL: I recall thirty-one years
20 ago when I came in as a young chemist and I thought
21 I would find a whole lot of other fellows with bald
22 heads and white coats in a great big laboratory, but
23 there is not one. It would be impossible. There is
24 not a patent office in the world that could begin to
25 test all the inventions which are presented to us.
26 You can reproduce some things, but how are you going
27 to reproduce a bridge or hydrogen bomb?

28 THE CHAIRMAN: I think that is under-
29 standable.
30



1

2

MR. MICHEL: We have no tests at all.

3

Our engineers are there. I have 105 engineers and

4

chemists, electrical engineers, mechanical, and

5

chemists, and everyone is a qualified university

6

graduate, and is a specialist in one or more or a few

7

fields.

8

THE CHAIRMAN: How many other employees,

9

just as a matter of interest?

10

MR. MICHEL: I have a staff of slightly

11

over 300 now. I have 107 I think with the exclusion

12

of the Assistant Commissioner. I have 107 engineers

13

of all denominations, and there is the Assistant

14

Commissioner who is an electrical engineer, and myself.

15

THE CHAIRMAN: To try to keep some order?

16

MR. MICHEL: We try to keep some order.

17

As long as everything goes smoothly, we don't care

18

about it, you know.

19

MR. RICE: Will you tell the Committee

20

what fees are attached to the registering of a patent?

21

MR. MICHEL: It costs to the government

22

\$60.00. \$30.00 on application -- what we call a

23

filing fee, and then after the examination, if the

24

invention is accepted, we advise the applicant and he

25

has six months to pay what we call his final fee, which

26

is also \$30.00 for the granting of this patent. It

27

costs \$60.00 to the government.

28

MR. RICE: Are there any amendments that

29

you can inform the Committee of under consideration

30



1
2 in regard to drugs in the Patent Act?

3 MR. MICHEL: The only thing I can say on
4 this is that -- and this is probably nothing new --
5 you are aware in 1954 a Royal Commission was appointed
6 by the Federal Government, and the Honourable Justice
7 Ilsley, Chief Justice of Nova Scotia, has been
8 appointed chairman, along with two other members, and
9 they have reported about 1957 or 1958 on the copyrights.
10 The Royal Commission was dealing with copyright, and
11 in 1958 I think it was they reported on the copyrights,
12 and in 1959 on designs, and they have this spring
13 reported on the 4th of April -- their report has
14 been tabled in the House of Commons, 4th of April,
15 1960, on patents and they have an extensive
16 recommendation there.

17 THE CHAIRMAN: Who were the other members?

18 MR. MICHEL: The other members were
19 Mr. Guy Favreau, Assistant Deputy-Minister of Justice
20 -- he has since, last August, left the Government,
21 and the other one was Mr. Buchanan. He was in the
22 Cabinet.

23 THE CHAIRMAN: He was Vice-Chairman of
24 the Tariff Board?

25 MR. MICHEL: Yes.

26 THE CHAIRMAN: Is that the official
27 report rendered?

28 MR. MICHEL: That is the official report,
29 and they have there made extensive recommendations, and
30



1 they have recommended a completely different Patent
2 Act than the one we have. In connection with drugs they
3 have recommended something which is in line with
4 what is now the law in Great Britain.

5 Back in 1919, after the war, Great Britain
6 decided to put some kind of restriction on chemical
7 inventions, and they adopted this Section 38A of their
8 Act, which was substantially a reproduction of our
9 present Section 41, except with this difference, that
10 subsection 1 of that Section 38 says "prepared and
11 produced by chemical processes". Ours is "prepared
12 or produced". "Prepared or produced by chemical
13 processes or intended for food and medicine". "Or
14 intended", and we have "and", so that from 1919 to
15 1949 when they changed their Act you couldn't patent a
16 chemical product in Great Britain. Everything was
17 excluded. But in 1923 in Canada the substance of
18 theirs was broadened to the Canadian Patent Act.

19 Some people are still claiming that the
20 Queen's Printer made an error in printing the Bill,
21 but we know for a fact the thing had been well thought
22 out, and the restriction in Canada has applied to
23 drugs only.

24 THE CHAIRMAN: Before you go on, I think,
25 Mr. Secretary, you should arrange to file that report
26 having in mind the pertinent sections pertaining to
27 drugs.

28 MR. MICHEL: I'm sorry. I should have
29 brought another copy. This one here is all marked up.
30



1 It can be obtained from the Queen's Printer I think, and
2 by the way, Mr. Chairman, I have here a couple of
3 copies of the Patent Act. I will leave one with you,
4 and the rules, and I think the other copy is the one
5 the stenographer has, and they will turn it over to
6 the Secretary.

7 THE CHAIRMAN: Is there any way, Mr. Michel,
8 in which the patent right could be cancelled through
9 the Department?

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11
12 (Page 832 follows)
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1 MR. MICHEL: Patent right cancelled by the
2 Department? There is nothing to that effect stated in
3 Section 41 for Food and Drugs but in connection with
4 the licensing provision of Section 67, the revocation
5 of a patent is still there but it has never been used
6 in Canada. It is only the very, very last resource.
7 That is, if no licence in remedy -- licence can be
8 remedied, something like that. It has never been
9 invoked and I cannot see that conditions will become
10 such in Canada that we will have to invoke the
11 section. After all, the licensing provisions are
12 there.

13 MR. RICE: Just one further question I want
14 to ask, Mr. Michel, on the application to you under
15 Section 41, is the evidence that is adduced by the
16 manufacturer to you of a confidential nature? In other
17 words, have the public a right to have access to that
18 information or is there confidence there?

19 MR. MICHEL: The public has access to it
20 after the thing is finished. You see, Section 41 was
21 dropped from the British Act in the Canadian Patent
22 Act. There is no regulations. There is no one
23 regulation governing these sections at all. I can do
24 whatever I want with it and on this, I have been
25 brought to Court in 1950 was the first case I was
26 brought to Court with. Justice Fournier in the
27 Exchequer Court said there being no regulation, the
28 Commissioner of Patents can draft his own regulations
29 in connection with the proceedings under Section 67
30



1 for compulsory licensing for failure to manufacture
2 within three years.

3 MR. RICE: What I was trying to direct you
4 to, Mr. Michel, was if the evidence, if it were taken
5 down, or there was a record made of the evidence the
6 Committee could avail itself of it.

7 MR. MICHEL: I base myself on Rule 109 in
8 connection with compulsory licensing, Section 67.
9 Rule 109 says:

10 "Any person may inspect any document filed
11 "in connection with the proceedings and may
12 "by written request addressed to the
13 "Commissioner obtain a copy of such docu-
14 "ment on payment of the statutory fees."

15 That is in connection with those other sections.
16 I do not see any reason why under Section 41 it should
17 not be the same thing.

18 As a matter of fact, I have given, or not
19 given away but for a fee, regular fee as set by the
20 rules, given copies of my rulings, and all my decisions
21 on compulsory licensing are found in Fox's bound cases.
22 You go back to 1950 you will find all of them.
23 Mr. Fox compiles them and puts them in. These are
24 my decisions and reasons for it.

25 The transcript of the hearing, I have doubt.
26 You see, there is no provision in the patent office
27 for having a transcript made. The patent office is
28 not allowed to pay for these transcripts so I say
29 to the parties when I start the hearing, when I call
30



1
2 for a hearing I say as there is no provision in the
3 Patent Office for a transcript, if you want one you
4 arrange yourself to get a reporter and have a trans-
5 cript made. That is the end of it. Now after the
6 hearing is finished, the transcript is given to them.
7 Out of their good heart they give one to me.

8 Now I still don't know whether I have the
9 right to copy and sell it or not but I have shown them
10 to people who have come to the office. I think it is
11 fair. Nothing tells us it must be held in camera.

12 MR. RICE: Is there anything further that
13 you would like to add or inform the Committee, having
14 regard to the terms of reference of the Committee?

15 MR. MICHEL: Not that I think of at the
16 moment. There is the question we have just left in
17 the air, to a certain extent, the question as to what
18 is an amendment and I started to explain the report of
19 the Royal Commission here; this report has not been
20 studied yet by the Cabinet, not even by the Committee.
21 We haven't given study to the report on copyrights and
22 the one on designs and we haven't touched the patent
23 report. We are going to start before long. What will
24 come out of it, we don't know.

25 We don't know whether these recommendations
26 will be accepted by Cabinet or whether they will decide
27 to recommend something else. We still don't know
28 exactly. It is definite there will be an amendment to
29 the Patent Act within the next few years, and the
30 Committee here, the Royal Commission rather here



1 recommends a slightly different scheme for drugs, which
2 scheme is in accord with the amendments made to the
3 British Patent Act in 1949. That is, the elimination
4 of Section 41(1). You understand what it means? The
5 drugs themselves, if this amendment is passed, the
6 drugs themselves, the substance, the chemical product
7 will become patented so that any manufacturer, any
8 lab who will discover a new drug will be able to obtain
9 patent for his product.

10 THE CHAIRMAN: As against the process?

11 MR. MICHEL: As against the process. He may
12 be able to obtain a patent for his process and a
13 patent for his product in accord with Rule 57, 58 and 59;
14 he will be able to put them both in the same patent.
15 We regard that as one invention.

16 If you introduce a new drug and to have at
17 the same time a new product, that invention may be
18 patented. In arriving at this product you must have
19 gone through certain number of steps, which becomes
20 a process and if it is patentable you have made an
21 invention. In that case, in order to obtain your
22 product you must carry your process through. When
23 you carry your process you naturally arrive at the
24 product so we regard that as one invention so that
25 if this is accepted we will give patents for the
26 products but they will still be liable to licensing,
27 just the same.

28 Now this may have some advantage, great
29 deal of advantage because as you know, as you proceed
30



1 in a game you get more company, and you always find
2 more tricks. In preparing to obtain application, you
3 must be an expert on patents, and to frame a claim --

4 THE CHAIRMAN: It might be said there is an
5 art that is attached to it?

6 MR. MICHEL: There is an art, and there is
7 quite an art, with a big A in drafting the claims.
8 Now what is happening now is that -- and we cannot
9 blame them -- the manufacturers are trying to go
10 around these provisions of Section 41(1) with the
11 result we have trouble in the office. The practice
12 in the office was that this section is there, food
13 and medicine. Now, when they find a new product and
14 it has some medicinal properties, turn around and find
15 out this product could not be applied industrially,
16 in some other field and if they do then they come up
17 with three or four uses, one for drugs, one for the
18 die industry, and something like that, the practice
19 of the office, the practice before my time has been
20 in those cases grant a product claim which puts them
21 in better standing than if they were only restricted to
22 their use for drugs.

23 THE CHAIRMAN: Of course what we are
24 talking about now, we are trying to prognosticate the
25 future and that is not our province or right to ask you
26 about government policy, your government policy.
27 However, if I am unreasonable please tell me, would I
28 be fair in saying there are pressures or trends towards
29 implementing product patenting in this field with
30



1
2 respect to drugs? Would that be a fair statement?

3 MR. MICHEL: No, I don't think there is any
4 pressure. I think I can say honestly, it is not a
5 policy of the Government, I don't think there is any
6 pressure to implement that. As I say, I cannot
7 expound the government's policy. It is a fair
8 question to ask ourselves whether the new system would
9 not be better than the one we have now. This I
10 have not made up my mind on yet. When I make up my
11 mind the Government may say I am all wrong, but at least
12 if you patent all the product itself, you go to that
13 man who owns that patent and that is all right.

14 Now, what happens is that the first to invent
15 the product, he patents his process. It is on the
16 market. He puts it on the market. The other people
17 look at that patent and say I can't use that process
18 if it is patented, that so-and-so won't give me a
19 licence so he starts to look around, this other fellow
20 starts to look around and finds another way to make
21 that product which is absolutely fair within the law,
22 and he makes that product and his process may be
23 better.

24 A third fellow may do the same thing, and
25 the end of the thing is another fellow, who doesn't
26 want to make some research, but who has the equipment
27 and knowledge to manufacture, he looks at all the
28 patents and he says this third patent is a very nice
29 process, much better than the process on the first one,
30 so he goes and asks for a licence to manufacture under



1
2 that process, and the first one who invented the
3 product is left holding the bag. Has no compensation.
4 Is it fair? Is it wrong? I don't know. This is the
5 question we must concentrate on.

6 THE CHAIRMAN: We must recognize that this
7 Committee's objectives are not entirely the same as
8 the objectives of the Patent Office.

9 MR. MICHEL: That is right.

10 THE CHAIRMAN: I gather from what you say
11 that as an experienced administrator of the operation
12 of licensing of patents, that you can see the desirability
13 of a change of legislation towards establishing
14 the right to patent the resulting product as against
15 the processing theory?

16 MR. MICHEL: Well, this is one side of the
17 picture. I put that picture before your eyes there
18 to exemplify a point. If I look only at the Patent
19 Office, the administration would be simplified but my
20 duty is not to look simply at the administration of
21 the Patent Office. I think my duty is to look and
22 advise the government for the good of the Canadian
23 public then if it happens that this advice makes the
24 office easier to run, the administration easier, so
25 much the better but if it does complicate it, I must
26 bear the consequences.

27 Now, this system which I have just explained
28 there has been adopted in Great Britain in 1949.

29 MR. RICE: I have no further questions, Mr.
30 Chairman.



1
2 THE CHAIRMAN: Anyone else? Mr. Price?

3 MR. PRICE: Yes, Mr. Chairman. I wonder if
4 I could ask Mr. Michel if he might estimate how much
5 the public is saved by the regulations of licensing rights
6 practice held in this country?

7 MR. MICHEL: I would be absolutely in the
8 dark on that.

9 MR. PRICE: Would it be thousands, hundreds
10 or thousands?

11 MR. MICHEL: Frankly, I would be -- it is
12 only a few licences which I have granted and hundreds
13 of licences which have been granted voluntarily on
14 account of the existence of Section 41 (3). I don't
15 know, so that it would be absolutely impossible to
16 try and put a figure on that, sir.

17 MR. TROTTER: Mr. Chairman, I just have one
18 question. I understand that you told us that a patent
19 is good for 17 years. How long can a company drag
20 out its patent rights by using the term "patent
21 pending"?

22 MR. MICHEL: Patent pending, in the first
23 place the words patent pending do not appear in the
24 Act at all. Patent pending is a term that can be
25 legally used since it is not restricted by the Act
26 because this privilege to obtain a patent means you
27 have an application before the office and still don't
28 have your patent -- some people say, well there is a
29 little joke here about who is the patent professor who
30 is the most prolific inventor in the world. The answer



1 is: Pat Pending.

2 MR. TROTTER: The reason, Mr.Chairman, I
3 asked this is that the inventor would have control of
4 the product for seventeen years, but in truth I feel
5 that in many instances, I don't know if this may be
6 applied to drugs, but possibly before they first
7 apply to the patent office the procedure goes on
8 literally for years. Finally they get the patent and
9 then before the 17 years expires they improve them, some
10 slight change to requisition a patent and so the
11 procedure goes on and on. Now, is that actually done
12 in practice very much or especially in relation to
13 drugs?

14 MR. MICHEL: They cannot do that. You see
15 they have a patent in the first place that is good for
16 17 years. After 17 years no matter what improvements
17 have been made on it that patent falls in the public
18 domain, but then their improvement will be good for
19 17 years. Take all this thing here, as soon as a
20 patent has had a life of 17 years, anybody can use it
21 so that if the company has a basic patent today, and
22 in five years from now they patent an improvement
23 on it, then for the remaining life of the first patent
24 they could use both entirely without any -- it would
25 be protected subject to licence only. At the end of
26 17 years, the first one will fall.

27
28
29 --- (Page 842 follows.)
30



1 MR. TROTTER: Would the improvement, if it
2 was fairly large, be considered as a new product,
3 an entirely new item?

4 MR. MICHEL: If you talk about improvement,
5 you have not got an entirely new item. You can say
6 you improve after the expiration of the first patent,
7 the patentee will be protected for that improvement,
8 or for that improved product, but anyone may make
9 a product. You cannot stop anyone from making the
10 product from the first process.

11 THE CHAIRMAN: Mr. Trotter, the best advice
12 I have for you is our matters of patent laws are highly
13 involved.

14 MR. TROTTER: It seems to me on occasion
15 some of these companies can keep the control of the
16 market by dragging out the procedure of this matter
17 known as "patent pending".

18 THE CHAIRMAN: What is the effective date
19 of a patent, the date of the application or the
20 date of issue?

21 MR. MICHEL: In Canada and in the United States
22 which I think are the only two countries in the world,
23 the patent dates from the date of issue, they apply
24 for patent and we process through our office and
25 they have the means to stall to a certain extent.

26 We are swamped with applications. We get
27 them at the rate of 25,000 a year. I have 75,000
28 pending in the office now. On the average, the average
29 time of pendency, that is the time it takes us to process
30



1 an application, is about three or three and one half
2 years. This time is not only due to the fact that
3 the patent office is late, but there is correspondence
4 involved.

5 They present their applications and they
6 try to cover as much as they can. From our records,
7 we receive it and try to cut it down to size.
8 That means correspondence. Everytime we call for
9 a report, I guess that means we have an objection and
10 they have six months to answer, and we look after
11 it as soon as we can, but it takes another six months.

12 There are companies that will try to maintain
13 they want it this way, and we keep on saying "no"
14 and there are arguments going on. Sometimes they are
15 in good faith. In most cases they are in good faith,
16 and in some cases there have been examples of stalling,
17 I would not say malicious stalling, but probably 75
18 per cent of the applications come from the United States,
19 and naturally they try to get in Canada a patent of
20 about the same scope as their patent in the United
21 States.

22 THE CHAIRMAN: Let me put this to you, are
23 the patent laws in Canada on all four's, generally
24 speaking, with those of the United States or not?

25 MR.MICHEL: Generally speaking, yes.

26 THE CHAIRMAN: Generally speaking they are.
27 With respect to applications for drug patents, what
28 is the source of the applications? Is it from the
29 United States, Europe or Canada? Is that an unfair
30



1 question?

2 MR.MICHEL: It is not unfair and I will
3 try to answer that although I do not have the records
4 here. In a general way 70 to 73 per cent -- it
5 varies a bit from year to year -- of our applications
6 come from the United States. That is for drugs or
7 other things. I think it is about 10 per cent coming
8 from Great Britian. Last year 4.9 per cent originated
9 in Canada. That may surprise you.

10 THE CHAIRMAN: It is very interesting because
11 one of the things we are concerned about is the amount
12 of research or initiative in Canada.

13 MR. MICHEL: My explanation to the Minister
14 at the time of the estimates was this, "Well now,
15 Mr. Minister, don't forget that we have here a young
16 and a prosperous country and our people are no worse
17 than the people from other countries. Since they
18 are just as good and just as intelligent and our
19 engineers and scientists are just as good or maybe
20 better in some fields. We have a country which is
21 coming up very fast. If you look at the records,
22 practically all inventors or manufacturers from other
23 countries take the patent home, apply for a patent
24 at home, and next in Canada." They all come to
25 Canada and seem to be looking for prosperity in Canada,
26 and that is why we have so many patents.

27 THE CHAIRMAN: Would the 4.9 or 5 per cent
28 of the drug patent applications be a fair figure
29 of the initiative of the drug research industry in Canada,
30



1 having in mind the parent company factor and so on?

2 MR.MICHEL: Yes, that is the difficulty.

3 I think it would be.

4 THE CHAIRMAN: That is from your point of
5 view?

6 MR. MICHEL: I think it would be fair. You
7 see, so many Canadian drug manufacturers have tied up
8 with United States people.

9 The research is mostly done in the United
10 States. The United States is not going to duplicate
11 the research routines so that the research is made
12 over there.

13 MR. FULLERTON: It would still be charged
14 up against the product which is being manufactured
15 in Canada, that portion of research that was made
16 in the United States.

17 MR. MICHEL: Oh yes.

18 THE CHAIRMAN: To be scrupulously fair,
19 would this witness be able to say anything about the
20 merchandise and the selling price? How does he know?

21 MR. FULLERTON: He has to do with costs.

22 THE CHAIRMAN: Would he have anything to do
23 with the selling price?

24 MR. FULLERTON: Do you take into consideration
25 the selling price when you are granting a licence?

26 MR. MICHEL: The selling price of the finished
27 product is very deceitful.

28 MR. FULLERTON: Or the cost price, at least?
29
30



1 MR. MICHEL: I usually take the selling price
2 of the crude drug to the person who will package it
3 and put it into a finished product, because the mark-up
4 from the crude drug to the bottled product that comes
5 to the corner druggist is so high. There is a big
6 variation there, too much of a variation, and I have
7 found that the mark-up is quite different from one
8 product to another when it comes out finished. I
9 usually don't go for that very much.

10 THE CHAIRMAN: Are there any other questions,
11 gentlemen?

12 MR. BOYER: Mr. Chairman, I was wondering
13 if in your opinion whether the witness could give us
14 or make available to the secretary of the Committee
15 lists of patents of drugs for us and also lists which
16 were referred to in evidence this morning of applications
17 for patents. Would that help us?

18 THE CHAIRMAN: We have to consider how is
19 that going to help us comment on the price of drugs.
20 I don't think the lists of those applications mean
21 anything. The number of applications for patents
22 in toto might have some relevandy.

23 MR. BOYER: That has been given.

24 MR. MICHEL: That would take months. We
25 have 70,000 applications to go through and it is no
26 mean task to pick up an application and find out whether
27 it is for a drug or not. Insofar as applications
28 which have been issued for patents, Section 10 of the
29 Patent Act prevents us from giving details.
30



1 MR. BOYER: The papers that you were using --

2 MR. MICHEL: Well, there is a list here
3 of applications for licences.

4 THE CHAIRMAN: Under existing patents?

5 MR. MICHEL: Under existing patents.

6 MR. BOYER: It may be helpful to us.

7 THE CHAIRMAN: Would you have any objection
8 to leaving that with the secretary, Mr. Michel?

9 MR. MICHEL: I have no objection to that.
10 As I said awhile ago, there is no regulation against
11 it. Insofar as Section 69 is concerned, anyone can
12 look at the thing, and I have this here, and those
13 that have proceeded to the end are all reported.

14 THE CHAIRMAN: Mr. Secretary, the only signi-
15 ficance that information would have, would be as
16 I see it, there are X number of applications within
17 a specified period of time having to do with applications
18 for licences to manufacture under Y number of patents.
19 Would that be accurate?

20 MR. MICHEL: Yes you may have that.

21 THE CHAIRMAN: Now, are there any other
22 questions, gentlemen?

23 Well then, you have been very kind, sir.
24 It is now almost 1:30, and before we adjourn I would
25 like to make this observation to you. Firstly I
26 would like to tell you sir that we on the Committee --
27 I will speak for myself and I am sure I speak for
28 the members of the Committee -- recognize the gracious
29 generosity and the voluntary attitude that you have
30



1 adopted in coming before this particular Committee,
2 having in mind the jurisdictional aspects.

3 Firstly I would like to tell you, "Thank
4 you for coming". Secondly I would like you to take
5 a message from this Committee back to your minister
6 and tell him that we appreciate the co-operative spirit
7 which is exhibited in you coming here. Thirdly,
8 the third item is somewhat different and is on
9 a more personal basis. The members of this Committee
10 are very conscious of the part played by civil servants
11 in this country, whether it be federal-wise and provincial-
12 wise.

13 The great strength of the provinces and
14 of the country lies in those people who have adopted
15 public service as a career, and you, sir, are one of
16 those. We would like to tell you that we recognize
17 the great part you play. We also recognize the great
18 talents that exist within the civil service and the
19 part that they contribute to our destiny.

20 Now, sir, I am trying, without becoming
21 emotional, to tell you, and through you to speak to
22 people such as you, that we appreciate your coming
23 and the part you are playing in this country's welfare.
24 Thank you.

25 MR. MICHEL: Thank you very much, Mr.
26 Chairman. I thank you for your kindness and your kind
27 attention and thank you for bearing with me. It has
28 been a pleasure to contribute a little bit, if I
29 have contributed something to the work of your committee.
30



1 I might say that I have enjoyed this session very
2 immensely and thank you very much. I shall bring
3 your message to the Minister

4 THE CHAIRMAN: We will adjourn until 10:15
5 tomorrow morning.

6
7 ---Adjournment.
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K. T. Lyden

Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO ONTARIO

VOLUME No.:

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Thursday,
the 20th day of October, 1960,
at 10:15 a.m.

COMMITTEE:

MR. H. L. ROWNTREE, Q.C. Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G. F. LAVERGNE

MR. S. J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE, Committee Counsel



1
2 --- On resuming at 10.15 a.m.

3
4 THE CHAIRMAN: Gentlemen, this morning
5 we are to hear from Doctor Morrell, who is the Director
6 of the Food and Drug Directorate of the Department of
7 National Health and Welfare in Ottawa. It will be
8 apparent to all of us that this particular department
9 has very close contact with the drug industry.

10 If you would care to proceed, Mr. Rice.

11 MR. RICE: For the purposes of the record,
12 would you state your full name, please?

13 DR. MORRELL: My full name is Clarence
14 Allison Morrell.

15 MR. RICE: What is your position with the
16 Food and Drug Directorate?

17 DR. MORRELL: I am the Director of the
18 Food and Drug Directorate.

19 MR. RICE: In addition you have got
20 "Dr." attached to your name. What kind of doctor is
21 that?

22 DR. MORRELL: PhD in medical sciences,
23 speciality from Harvard University in
24 biochemistry.

25 MR. RICE: How long have you been a
26 director?

27 DR. MORRELL: I have been a director for
28 just a little over fourteen years.

29 MR. RICE: How long have you been associated
30 with the Directorate?



1
2 DR. MORRELL: I have been in the department
3 working -- prior to being director I was head of the
4 Pharmacology and Toxicology Section; I was there for
5 almost fifteen years. I have been about thirty-one
6 years in the Government service.

7 MR. RICE: Under what Government department
8 does this Directorate operate?

9 DR. MORRELL: National Health and Welfare.

10 MR. RICE: What acts govern the Directorate?

11 DR. MORRELL: The Food and Drug Director-
12 ate is responsible for administering two federal acts,
13 the Food and Drugs Act and the Proprietary or Patent
14 Medicine Act.

15 MR. RICE: Would you explain to the
16 Commission, Doctor, the organization of your Directorate
17 to carry on this work?

18 DR. MORRELL: Yes. We have a central
19 headquarters in Ottawa, and we have Canada divided into
20 five regions. In each region there is a laboratory
21 service, an inspection service, an office staff, and
22 then district offices. We have regional laboratories
23 in Halifax, Montreal, Toronto, Winnipeg and Vancouver.
24 We have twenty-one district offices in those regions.
25 The district officer reports to the regional head-
26 quarters within his region. In Ottawa we have a
27 laboratory service and inspection service and
28 administrative service. The laboratory in Ottawa is
29 specialized in that their main job is to carry out
30



1
2 research and investigation. This is usually confined
3 to devising of methods or improvement of methods of
4 analysis or detection. There may be some basic
5 research in connection with drugs or foods aimed
6 primarily in determining whether claims made for food
7 and drugs are justified.

8 Also in the Ottawa laboratory we do all the
9 biological testing that is required. This is done
10 because of the expense of maintenance of the various
11 regional laboratories.

12 In Ottawa, we have the headquarters of the
13 inspection services, too, and they do a great deal of
14 the national advertising and the labelling of national
15 products, and the administrative policy is set down in
16 Ottawa.

17 MR. RICE: Do you have a division directly
18 concerned with the Proprietary or Patent Medicine Act?

19 DR. MORRELL: Yes. Up until this year
20 it was a separate and distinct division. Now it has
21 been merged with inspection services, it forms a part
22 of the inspection services in the Food and Drug
23 Directorate.

24 MR. RICE: Dealing with that Act, would
25 you explain to the Committee what a patent medicine
26 is in terms of that, having in mind that we had Mr.
27 Michel yesterday from the Patent Office and he explained
28 patents in terms of his office.

29 DR. MORRELL: Well, a patent medicine under
30



1
2 the Proprietary or Patent Medicine Act is not patented
3 in the sense that Mr. Michel would understand probably
4 or recognize in connection with his own Patent Act.
5 I think up until about 1909, when the Proprietary or
6 Patent Medicine Act was first promulgated by Parliament,
7 medicines could be patented; -you could get a patent
8 for a combination of ingredients which protected your
9 interest from competitors.

10 In 1909 the Proprietary or Patent Medicine
11 Act was passed and a measure of that protection was
12 carried over into the new act, and the measure of
13 protection consisted of the secrecy of formula.
14 Originally it was intended to be a secret formula act.
15 Over the last thirty years or more this has become
16 less important. Nevertheless, the Proprietary or
17 Patent Medicine Act required the medicine to be registered
18 under that act, listing all the ingredients on the
19 label.

20 In the act, of course, the protection of the
21 public has been the main thing. There are certain
22 drugs, for example, narcotics, which are not permitted
23 to be registered under the Act; no new drugs are
24 permitted. Prescription drugs or drugs which -- yes,
25 prescription drugs is another category of drugs which
26 are not permitted under the act. Also official drugs
27 which are listed in the appendia, for example, the
28 British Pharmacopoeia, in the schedule to the Act. If
29 a drug happens to be in there it is not registerable.
30



1
2 In addition, for public protection, a number of drugs
3 are listed in the schedule to the act, and they may
4 be only added in certain quantities and the dosage is
5 restricted, and the presence of the drug must be
6 declared on the label.

7 So we have now under the Proprietary or
8 Patent Medicine Act an act which permits the registration
9 of a medicine and which gives a very small modicum of
10 protection to the manufacturer; the total list of
11 ingredients is not given on the label. However, the
12 really effective drugs that may be dangerous at all
13 are listed and the amounts are restricted.

14 MR. RICE: Is the patent medicine sold
15 under a brand or trade name? Are the medicines sold
16 under a brand or trade name, are they sold under brand
17 names?

18 DR. MORRELL: Yes, I think entirely so.

19 MR. RICE: And they also have a secret
20 formula character?

21 DR. MORRELL: Yes, there is a bit of
22 secrecy. It is really a joke now, but there is a bit
23 of secrecy about it.

24
25 (Page 860 follows)
26
27
28
29
30



1 MR. RICE: Anyone wanting to market a
2 product under a brand name with a secret formula,
3 is it compulsory for them to register under that Act?
4

5 DR. MORRELL: Oh, if he is going to maintain
6 any secrecy, even a modicum of secrecy that is permitted
7 by the P.P.M. Act, he must register.

8 MR. RICE: There are certain exceptions that
9 you have enumerated that cannot be registered?

10 DR. MORRELL: Yes, a great many drugs cannot
11 be registered.

12 MR. RICE: Is there a number or some way in
13 which the formula can be referred to from the label?

14 DR. MORRELL: When a manufacturer wishes
15 to register his product under the P.P.M. Act, he is
16 required to submit to the Directorate a complete
17 list of ingredients, medicinal and otherwise.

18 This is examined in the light of the Act.
19 The Act is gone over to see that there is nothing in
20 here that would be objectionable under its terms.
21 Further than that, it is considered as to whether it
22 would be safe and wise to register it, in addition
23 to the restrictions that are placed on it by the
24 P.P.M. Act itself. The claims that are to be made
25 must be given when the formula is submitted. There is
26 one --

27 MR. RICE: That is, the therapeutical claims?

28 DR. MORRELL: Therapeutical claims, what it
29 will do. We also must look at it to see that it is
30 not an alcoholic beverage disguised as a patent medicine.



1 This is a carry-over from the days of long ago which
2 maybe some of you have read about or knew about when
3 a great many patent medicines were alcoholic beverages,
4 but now that part is taken care of because it must
5 be sufficiently medicated to make it unpalatable or
6 unsuitable as a beverage. Those things are gone into
7 first of all.

8 If we have any doubts about the advisability
9 of registering a particular product, we have an
10 advisory board which is set up by Order-in-Council,
11 and consists of two physicians and two pharmacists,
12 and they are consulted either by mail or by inviting
13 them to come to Ottawa for conference, and we nearly
14 always take their advice as to whether it is or is
15 not suitable to register this product as a patent medicine.

16 We keep in mind also this product will be
17 sold possibly by outlets that are not drug stores;
18 are not under the charge of a pharmacist, and they
19 will be used by the general public on the basis of
20 self-diagnosis and self-treatment. So that all precautions
21 are taken to make sure that there is no harm if they
22 are used according to the directions.

23 MR. RICE: I understand, Doctor, there is
24 a system of giving these formulas a number. Would you
25 explain that?

26 DR. MORRELL: I'm sorry, I didn't really
27 answer your question. When it is agreed that the
28 product may be registered, the manufacturer of it will
29 be licensed if he hasn't already a licence for other
30



1 products and the particular medicine itself will
2 receive a number, which is the registration number.
3 That number will accompany that product as long as
4 that product is sold on the market.

5 If the formula is changed, of course the
6 manufacturer must notify us, and the same procedure
7 is gone through again to make sure that the change in
8 the formula has not altered our views as to its
9 safety and value, so that if it is changed, he receives
10 a new number.

11 MR. RICE: When these patent medicines
12 are marketed, what must appear on the label of the
13 patent medicine.

14 DR. MORRELL: Well, the name of the manufacturer,
15 the name of the product, when there is a schedule
16 drug in there, the name of the drug and the amount
17 present; the maximum single dose and maximum daily
18 dose is also given. Net contents are required -- that
19 is, how many tablets or how many ounces, and the
20 registration number must be clearly and distinctly
21 given on the patent medicine.

22 MR. RICE: Now, in this testing, is there
23 any clinical test made in connection with an application
24 for patent, or to register a patent medicine?

25 DR. MORRELL: No, no clinical tests are
26 required for patent medicines. I should point out
27 they consist of long-established drugs, the safety
28 and value of which has been demonstrated in most
29 cases over a great many years, for which a clinical test
30



1 is not necessary for registration of a patent medicine.

2 MR. LAVERGNE: Before we go any further,
3 just enquiring about when Mr. White asked about this
4 volume, I understood you to say there were no new
5 drugs. There are no new drugs permitted. What is
6 the essence of that, no new drugs permitted?
7

8 DR. MORRELL: Perhaps I have to define
9 a new drug to explain that. A new drug is a product
10 which may be entirely -- have been previously quite
11 unknown; the chemical structure for example has not
12 ever been used in medicine before, and has been developed
13 by some manufacturer or some research laboratory and
14 found to be effective in a particular disease. Penicillin
15 is an example of a new drug in this day. Many of
16 the new tranquillizers were in that class and are still
17 in that class in some cases. This is one type of
18 new drug.

19 Now, if a new, a distinctly new claim is
20 made for an established drug, that itself becomes
21 a new drug, or if a new method of introduction into
22 the body is recommended or is going to be recommended,
23 that becomes a new drug.

24 For example, if some product which was well
25 known over the years is effective and safe when
26 given by mouth, and is recommended to be given by
27 injection, it becomes a new drug at that point.
28 Now, none of these products are allowed in patent
29 medicines. None of these new drugs, according to
30 our definition in our Food and Drug Act, is allowed



1 in patent medicines. The reason is, of course, that
2 we want to make sure, we want to be as sure as possible
3 that a drug is well established with many millions
4 and millions of doses, or people have used it, and
5 that the knowledge of the effects is very extensive.

6 MR. RICE: I understand in addition to register-
7 ing these patent medicines, they must also obtain a
8 licence. Will you tell the Committee the effect and
9 scope of these licences?

10 DR. MORRELL: The company itself is licensed,
11 and the licence, of course, has to be reviewed each
12 year. There is a small fee paid for the licence and
13 registration, but it is insignificant in amount.
14 However, our licensing gives us opportunity to review
15 on an annual basis all of the medicines that have
16 been registered, and all the firms that have been
17 licensed.

18 It also provides a weapon, I might say,
19 that if a sufficiently dangerous violation of the
20 P.P.M. Act has been committed by a manufacturer, we
21 may withdraw his licence, which means that he can no
22 longer sell in the way he has sold any of the medicines
23 that he makes that have been registered.

24 This is a very useful thing to have, and
25 we have used it on occasions.

26 MR. WHITE: Is there an appeal provision
27 against that?

28 DR. MORRELL: Written into the Act, no.
29 There are plenty of appeals, of course.
30



1 MR. WHITE: The appeals come to you?

2 DR. MORRELL: They can go to the Minister,
3 of course.

4 MR. RICE: This licence then has to be re-
5 newed annually?

6 DR. MORRELL: And this is the time when we
7 do review all we know about, and if there have been
8 any objections, this is the time to stop the registration
9 or to refuse to renew the licence.

10 MR. RICE: It gives you an opportunity to
11 eliminate worthless drugs or harmful drugs?

12 DR. MORRELL: Yes, and other things, too.
13 If the manufacturer changes his formula and does not
14 tell us, and our analysis shows he has done so, this
15 is an opportunity to point this out to him in a very
16 strong way.

17 MR. RICE: Can you give the Committee
18 any estimate or figure as to the number of patent med-
19 icines that are licensed in Canada?

20 DR. MORRELL: May I say the number of patent
21 medicines that are registered in Canada? The licence
22 goes to the manufacturer. He may make a dozen.
23 The number of medicines that are registered under
24 the P.P.M. Act would be somewhat over three thousand.

25 THE CHAIRMAN: If I may interrupt, Mr. Rice,
26 for a moment; Dr. Morrell, we of course are concerned
27 primarily with drugs which are normally prescribed
28 by a physician. Now, I wonder if we shouldn't distinguish
29 carefully between the patent medicines of the cough syrup
30



1 type as against those drugs which might be available
2 by direct purchase to a customer, that yet come
3 within this area with which the Committee is concerned.

4 DR. MORRELL: While I am not an authority on
5 that, Mr. Chairman, my experience tells me that very
6 few of these registered proprietary patent medicines
7 are prescribed by physicians. Very few physicians
8 would prescribe them.

9 THE CHAIRMAN: And there is a greater freedom
10 in the type of advertising to promote and sell these
11 medicines.

12 DR. MORRELL: I think we try to make it
13 a little more difficult to be too expansive in the
14 advertising because we have this in mind: this
15 advertising is addressed to the general public who
16 cannot be expected to be critical or informed about
17 what is said. We are not interested in advertising --
18 well, we are interested, but we don't interfere in
19 advertising to the professions, and a great many of
20 the other drugs are not advertised directly to the
21 general public.

22 I think a good deal of the advertising
23 of medicines in newspapers and so on covers these
24 licensed proprietary patent medicines.

25 MR. BRYDEN: May I ask before you resume,
26 Mr. Rice, a product like aspirin, would that be a patent
27 medicine? Would that come under this Act, or where
28 does it fit in?

29 DR. MORRELL: I can't tell you whether that
30



1 particular brand. ---

2 MR. BRYDEN: Just taking it generally.

3 DR. MORRELL: Well, some acetylsalicylic,
4 if in combination with something else, is registered.
5 A single drug of that type is not registered; it
6 is in the Pharmacopoeia, and they can make a combination
7 of it and have some other additional value, and we
8 don't register it, but there are a number of analgesics
9 of that type containing one or more additional
10 ingredients that are registered.

11 MR. RICE: Has the Directorate any control
12 over the price of these patents or proprietary medicines?

13 DR. MORRELL: None whatever.

14 MR. RICE: Are there a number of similar
15 patents or proprietary medicines on the market? That
16 is, under different names?

17 DR. MORRELL: You mean one similar to the
18 other in composition?

19 MR. RICE: Yes.

20 DR. MORRELL: Oh yes, there are. I would
21 say a fair proportion of them are duplicates of other
22 drugs. Some of them probably would be nearly identical
23 except for the incipient or vehicle in which they
24 are contained.



1 They would be nearly identical, or identical
2 in terms of so-called active ingredients.

3 MR. RICE: To return to the work of the
4 directorate in the Food and Drug Act, what is the
5 general work of the directorate under that Act?

6 DR. MORRELL: Well, I presume you want me
7 to confine myself to the drug angle. Therefore, the
8 Food and Drug Act is a statute that is considered to
9 be criminal law. It is intended to protect the
10 consuming public from danger to their health and
11 from faulty deception in the sale of drugs, etc., and
12 it lays down certain provisions and I suppose in the
13 lawyer's terminology it creates certain crimes.

14 It has prohibitive features: no person
15 shall sell this and that, and by being criminal law,
16 of course, it doesn't guarantee that there will be
17 no crime. The intent of the administrator is to find
18 out what does go on, and to correct faults or violations
19 of the Act and the Regulations, and also of course when
20 all else fails, to punish those who will not adhere to
21 the law.

22 MR. RICE: To carry out these activities,
23 at what level of the industry do you do it, or do you
24 do it at all levels?

25 DR. MORRELL: We have authority under the
26 Act to do it at all levels. It says no person shall
27 sell. It is usually based on that premise, where there
28 has been a sale.

29 Where a sale is made, it includes distribution
30



1 and cost, I presume, so that we can take samples from
2 the retailer, the wholesaler and the manufacturing
3 level, and if faults are found in the products, or
4 other things, the latest examples, we have authority
5 to prosecute at that level.

6 There is a protection, however, for the
7 retailer and I presume the wholesaler in that if he
8 can show to the Magistrate or Judge that the product
9 received by him was already prepared and packaged,
10 and that he had no reason to doubt its truthfulness
11 or accuracy, and that he did nothing to alter the
12 factors in the product, he is home-free, and we must
13 therefore go one step farther back to the manufacturer.

14 Now we find that it is more economical and
15 efficient to do a large part of our enforcement at
16 the manufacturing level because then we do not have
17 these large number of prosecutions for the sale of one
18 particular product, and one particular batch of the
19 product. We can go to the manufacturer and deal with
20 him directly.

21 MR. RICE: And what about the imports coming
22 into the country. Is there any check made on that?

23 DR. MORRELL: The Food and Drug Act, and
24 the P.P.M. Act too do not or are not, of course,
25 confined to drugs manufactured in this country.
26 They are confined to drugs sold in this country, and
27 it doesn't matter what the origin of the drug was.
28 It might be in Europe or United States or in Canada.
29 It is one and the same so far as the Food and Drug
30



1 Act is concerned, so that we do have inspection of
2 imports, and the same standards and requirements are
3 expected of an imported drug as pertain for a domesti-
4 cally prepared drug.

5 We have authority to refuse drugs that do not
6 comply with the requirements of the Act. We hold them
7 in Customs so that they do not really come into the
8 country.

9 MR. RICE: In your inspection examination of
10 drugs, what in particular do you test or examine for?

11 DR. MORRELL: Well, there are a number of
12 things, of course. We deal with different classes of
13 drugs really in different ways. I don't know whether
14 you want me to go into detail on that. If you do,
15 then I will be prepared to.

16 MR. RICE: I had in mind the five headings
17 here, availability, strength.

18 DR. MORRELL: Well, those are the qualities
19 that we look for in each and every drug, no matter
20 how we deal with it under the Act.

21 We want to know, of course, that the product
22 which is advertised as such-and-such, first of all
23 whether it is really such-and-such and not something
24 else, and that means not only the identity of the act
25 of principal or principals but the quantitative amount
26 that is present in them at the dosage forms.

27 Secondly, we want to know about the stability
28 of the drug. In some cases, of course, the expiration
29 date is required; in other cases an expiration date
30



1 is not required but the manufacturer nevertheless is
2 responsible for a drug that has deteriorated in
3 potency just by standing on the shelf.

4 Well, I perhaps should modify that a little.
5 It may not be his fault in that some druggists may not
6 be as sharp about their stock as others and may
7 retain a product on the shelf for an indefinite period,
8 but nevertheless it is somebody's responsibility to
9 look after that.

10 We must be absolutely sure of the safety of
11 the drug, if it is used under the conditions under
12 which it is recommended. In that case, there must be
13 no harmful extraneous matter in the product either in
14 the form of insepient or impurities present.

15 Perhaps you could prompt me on some of the
16 other headings Mr. Rice.

17 MR. RICE: Availability and strength.

18 DR. MORRELL: Availability -- the strength
19 I did mention that. I said that we not only wanted
20 to know the identity of what is there, but we must
21 know how much is there, and that is the strength.

22 Availability is another important factor
23 which we have spent a good deal of time on recently,
24 and that means that when you take a pill of any kind
25 it must be broken off and the contents absorbed into
26 the system, if not for that particular drug at least
27 the therapeutic effect must be available to you.

28 Now you can make a tablet so hard, or coat
29 it in such a way that you take it in one end and it comes
30



1 out the other without having had any effect on you
2 whatever. Now it doesn't matter what the composition
3 of that pill is, it is of no use to you so we do look
4 and this is becoming increasingly important, we do
5 look carefully at the availability, the physiological
6 availability of the drug, so tests are made for that, and
7 it is in violation if it doesn't provide the medicine
8 that it contains.
9

10 MR. RICE: Are there any clinical tests
11 carried out in connection with these examinations?

12 DR. MORRELL: All new drugs and I tried
13 to describe the kind of drugs that are new, by virtue
14 of the composition or the structure, chemical, or by
15 virtue of the new use are obliged to go through a
16 certain drill, and the information is required by the
17 Minister to establish the safety. First of all, the
18 pharmacology of the drug in the laboratory, and
19 secondly, the clinical effects and the safety, and
20 the side effects. If there are any undesirable side
21 effects they must be determined by clinical trial.

22 The details of the clinical trial must be
23 sent to the Food and Drug Directorate where they are
24 reviewed. We examine, of course, at the same time the
25 claims that are to be made for that new drug, so in the
26 case of new drugs, clinical trials are definitely
27 demanded.

28 MR. RICE: What about the premises themselves
29 of the manufacturers and retailers? Are the premises
30 examined at all?



1 DR. MORRELL: The premises are examined.
2 They have two types, perhaps two types of examination.
3 There are certain drugs that are licensed under
4 Section 12 of the Food and Drug Act. These are the
5 kind of drugs that may be licensed which are listed
6 in one of the schedules to the Act. Really we can
7 say that these are the biological type of drugs,
8 the serums, vaccines and antitoxins, and so on, and
9 the antibiotic or parenteral use, that is in injections.

10 The manufacturers of these are licenced.
11 This licence is a very, I might say I think a difficult
12 one to get because before the licence is granted for
13 a particular product, the premises of the manufacturer
14 are carefully inspected and studied; the facilities
15 that he has, maybe the equipment or housing, the
16 personnel that will be in charge of the manufacturing
17 is also studied to determine their academic qualifica-
18 tions, and their experience on the job, and finally
19 the products which they propose to make are checked in
20 our own laboratories in Ottawa, for it may be --
21 depending on the company, depending on the product,
22 it may be many batches before they may be sold without
23 a release.

24 Now then, this is the type of inspection
25 and licence that will cover the Salk vaccine, which
26 you all know. Then there is the second category of
27 inspection in which no licence is given.

28 This is the general inspection for the
29 manufacture of pharmaceuticals, and we have a number of
30



1 inspectors. There is a specialist in our Toronto
2 office and laboratory here, a specialist on drug
3 inspection, and he has, I think I can say, undoubtedly
4 visited all of the manufacturing plants, the dis-
5 tributors, and perhaps the wholesalers too in this
6 region, and he has a card and form which he must fill
7 out on each inspection, and these of course are
8 recorded in Ottawa.

9 If he finds that the manufacturing facilities,
10 or control facilities are not adequate for the purpose,
11 it is his duty to bring it to the attention of the
12 manufacturer and to follow up at a later date to see
13 what changes have been made that improved the
14 situation.

15 THE CHAIRMAN: Have you ever cancelled any
16 of your licences?

17 DR. MORRELL: We have cancelled -- now the
18 licence, of course, I dealt with first. We have
19 cancelled and have suspended licences to this latter
20 group that I am now just talking about.

21 MR. BRYDEN: With regard to that latter
22 group, what remedy is there for the manufacturer who
23 pays no attention to the warning?

24 DR. MORRELL: At the moment, at the present
25 moment the remedy is to catch his products that are
26 in violation. That is not perhaps the whole remedy
27 because there are specific requirements under the Act.

28 If he is making parenteral products at all,
29 of course, he must see that they are sterile and
30



1 there are a number of specific requirements he must
2 carry out. All we can do is seize his product in the
3 sense of stopping his manufacture of that product
4 at least until he reforms, if we have to camp on his
5 doorstep, put it that way, and if we find them, then
6 we can seize and prosecute. I might say the
7 seizures are perhaps our most effective weapon of
8 enforcement.

9 MR. RICE: Is there any check on the manu-
10 facturer's promotional material?

11 DR. MORRELL: Yes, the advertising is
12 included in the Food and Drug Act. Certainly it is
13 applied in the proprietary patent medicines, so
14 that advertising can be defined and we have specific
15 controls as well as general controls.
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27 --- (Page 880 follows.)
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2 If I may read here. The definition of
3 "advertising" in the act is as follows:

4 "'advertisement' includes any representation
5 by any means whatever for the purpose of
6 promoting directly or indirectly the sale
7 or disposal of any food, drug, cosmetic
8 or device."

9 - and that is broad enough to include advertising by,
10 I think, any means. Most of our efforts are directed
11 at radio, T.V. advertising and newspaper and periodical
12 advertising.

13 MR. WHITE: What about advertising to the
14 medical profession, Doctor?

15 DR. MORRELL: No. We confine our
16 attention to advertising to the general public, because
17 we feel that the general public is not in a position
18 to know what is right, what is exaggerated or what
19 is false; whereas the medical profession are supposedly
20 at least a group of experts who are able to look at
21 them themselves, they should be able to know what is
22 reasonable and what is nonsense, and perhaps it is right
23 even if there is some who are not quite so alert,
24 because it might be considered as interfering with
25 the practice of medicine. So we have confined our
26 efforts to the control and survey, if I may use the
27 word, of advertising to the general public.

28 MR. BRYDEN: This would not cover any
29 description at all?
30



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2 DR. MORRELL: No, that is true. If I
3 could go one more, because this is, I think, important,
4 and it says here in Section 3 of the Act that

5 "No person shall advertise any food, drug,
6 cosmetic or device to the general public as
7 a treatment, preventative or cure for any
8 of the diseases, disorders or abnormal
9 physical states mentioned in Schedule A.

10 (2) No person shall sell any food,
11 drug, cosmetic or device (a) that is
12 represented by label, or (b) that he advertises
13 to the general public as a treatment,
14 preventative, or cure for any of the diseases,
15 disorders or abnormal physical states
16 mentioned in Schedule A."

17 If you look at Schedule A you will see a
18 list of the diseases which we feel, or somebody felt
19 -- and I believe they were right -- were of sufficient
20 seriousness that they should be diagnosed and treated
21 under the supervision of a qualified medical practitioner.
22 So it is an offence to advertise a drug as a treatment,
23 preventative or cure for cancer, diabetes, etcetera.

24 Now, those are the general terms of the act
25 under which we operate in supervising advertising.
26 I think it is a regulation of the Broadcasting Act
27 that all radio and T.V. commercials be submitted to
28 the Department of National Health prior to being used
29 on the air. These T.V. and radio commercials are for
30



1
2 food and drugs, and these come to Ottawa where they are
3 read and criticized on the basis of these terms, and
4 our criticisms are returned to the C.B.C., the
5 Broadcasting Corporation, who usually take our advise.
6 This is a rather effective means of controlling the
7 radio and T.V. advertising. I think last year we
8 examined about 29,000 radio or T.V. commercials in
9 English and French for foods and drugs.

10 MR. WREN: Do you feel that the T.V. claims
11 on patent medicines are genuine, represent a fair
12 presentation of the product?

13 DR. MORRELL: Well, that is pretty
14 difficult for me to say. I would say that they are
15 a lot better than they are when they come to us.
16 Certainly, I think they are better than they are in
17 other countries, and I have had complaints in this city
18 of T.V. and radio commercials, and when you have looked
19 into them, you will find they are from American stations,
20 which you get easily enough here, and not from Canadian
21 stations. I am not trying to say that the advertising
22 of any products couldn't be improved in my opinion, but
23 my opinion isn't altogether what the law says, and that
24 is what I have to operate by.

25 MR. WREN: For example, there is the
26 advertising of medicines for arthritis and rheumatism.

27 DR. MORRELL: What is the advertising?

28 MR. WREN: They get around it by saying if
29 you have symptoms of arthritic or rheumatic pains take
30



1
2 this and you will jump over the moon.

3 DR. MORRELL: Do they say the latter?

4 MR. WREN: They imply it. I know from
5 personal experience I haven't found any drug which is
6 prescribed which is worth ten cents. I think the
7 public is being taken in most gullibly by this.

8 DR. MORRELL: Well, salicitates is a mild
9 anaesthetic, and they are permitted. It may help,
10 you may see. It is all watered down at least.

11 MR. BRYDEN: A lot of that advertising
12 for arthritis and rheumatism is done by classified
13 ads.

14 DR. MORRELL: I am not working in that field.

15 MR. BRYDEN: I notice arthritis is not in
16 Schedule A, and there are reports of many quack
17 remedies.

18 MR. WREN: I find it is a very serious
19 disease, which I am told it should be only treated by
20 the medical profession, specialists in internal medicine.
21 There are hundreds and thousands of dollars spent by
22 helpless people who are victims of this advertising.

23 THE CHAIRMAN: This Schedule A, Mr. Wren,
24 to which Doctor Morrell refers doesn't have arthritis
25 in it. But let's look at Schedule A. For instance,
26 one item would be obesity, and that is a popular
27 subject at the moment, and one product appears to be
28 well advertised, trying to help people to take off
29 weight.
30



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2 DR. MORRELL: I know the one you are
3 speaking of.

4 THE CHAIRMAN: Would you have any comment
5 on that?

6 DR. MORRELL: Well, when you go to a lawyer,
7 what is obesity? Is it slight overweight? This is
8 what we are always faced with when we come to take
9 action. Is it a matter of presenting an increase in
10 weight, not necessarily an obese person but someone
11 overweight, and you have to consider all of that before
12 you can take legal action. I could only say -- and
13 this is perhaps a biased opinion, because I am interested
14 in this -- that our advertising in this country for
15 drugs is a lot better than in the United States. I am
16 sure of that in my own mind, at least, and that that
17 schedule and that clause in the act has had considerable
18 effect on the advertising in Canada.

19 MR. WREN: Of course, one must say our
20 people are influenced by the reception of American
21 radio and T.V. over which we have no control.

22 DR. MORRELL: Over which we have no control,
23 yes. It is one of our big problems in advertising.
24 One wonders sometimes whether or not to continue.

25 MR. RICE: Doctor Morrell, you have told
26 the Committee that your Directorate not only examines
27 and tests products but also the conditions under which
28 those products are manufactured in Canada. What about
29 the American product? Is it just a check on the
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1
2 product itself or can you check on the way it is
3 manufactured?

4 DR. MORRELL: There are two types of
5 inspection, one for licensed and one for products which
6 are not licensed. If a product is licensed for sale
7 in Canada, the premises, the facilities, the personnel,
8 the records are checked, no matter where they are.
9 We have manufacturers licensed in Europe as well as in
10 the United States; they cannot sell in this country
11 until they have met the requirements for a licensed
12 product in here. So we do send inspectors to Europe
13 and the United States. When it comes to the general
14 pharmaceutical, that is not so, we do not, and I don't
15 know whether we could, except by courtesy, inspect
16 plants in foreign countries; the law applies to Canada.
17 We have, by courtesy, been allowed to inspect plants
18 in Europe and the United States when no licence was
19 involve, but we have no authority to do so at the
20 moment. So all we can do in a positive way on imports
21 is to examine them at import. Many of them, of course,
22 come in in a partially manufactured form and the
23 completion of the manufacture takes place in this
24 country. In that case, as a rule, we do not take
25 samples. We look at the finished product as it would
26 be sold to the consumer; but when a product comes in
27 in a finished form we often take samples, although we
28 do not invariably take samples.

29 THE CHAIRMAN: Mr. Rice, would you deal
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1
2 with the question of bulk drugs?

3 MR. RICE: Would you explain to the
4 Committee how you examine these bulk products coming
5 into the country, how you examine them and take tests
6 of them?

7 DR. MORRELL: Well, in the port of Montreal,
8 for example, and in the port of Toronto our one
9 inspector at least visits the customs every day in
10 Montreal. We have a man permanently stationed in
11 the customs house; he has a desk and office there. If
12 I may take these two cities as an example of what goes
13 on elsewhere, they see all of the invoices and the
14 manifests of the products which are coming in, and when
15 they see drug products or products that they recognize
16 with basic materials to drugs, then they take samples.
17 Now, it depends on what it is, whether they do take
18 samples. They have instructions; there are certain
19 products which are sampled frequently, there are other
20 products which are not sampled frequently. The number
21 of samples sent in, of course, must depend on our
22 work load and our facilities and personnel to handle it.
23 So that bulk products may be sampled as well as
24 finished products at customs.

25 When a sample is taken that product is held
26 by the customs officer until the inspector receives
27 the report from the laboratory. If the report is
28 favourable, the inspector releases the shipment and,
29 of course, it is then sold in this country. If it is
30



1
2 unfavourable, it is held in customs and must be
3 returned or destroyed.

4 MR. RICE: Earlier, Doctor, there was
5 some reference to the Committee of counterfeit drugs
6 coming into Canada. Could you give the Committee
7 any information whether it is widespread or not?

8 DR. MORRELL: I would like you to explain
9 to me what you mean by "counterfeit drugs".

10 MR. RICE: That is a term which has been
11 used, and I was just using it.

12 DR. MORRELL: I presume a counterfeit
13 drug -- maybe I am wrong -- is probably an imitation
14 drug. If a manufacturer has a proprietary -- I don't
15 mean under the Patent Medicine Act; this is another
16 use of that term -- a proprietary is a product that
17 is the property of a manufacturer.

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... of a manufacturer. He has invented it, and has a patent on it, I presume, or at least he has a trademark and probably a brand name.

Well, a counterfeit drug is an imitation of that proprietary by some other manufacturer. Now, it won't be sold I wouldn't think -- in fact, I don't know. This is my opinion -- it wouldn't be sold under the same brand name. If it was sold under another name, it might be a generic name or it might be a brand name that the counterfeiter has registered himself.

MR. WHITE: In the case that Mr. Rice is referring to, the manufacturer was using another ----

MR. BRYDEN: He was imitating brand name products. It was referred to, I think, in New York they discovered a counterfeit ring where people were putting out products that imitated the exact appearance and the name and everything else.

DR. MORRELL: Did they label them as such?

MR. BRYDEN: Yes.

DR. MORRELL: That, of course, is a violation of our Act, but imitating in appearance and composition I don't think is a violation of the Food and Drug Act.

MR. WHITE: If it were substandard ---

DR. MORRELL: If it was substandard or otherwise unsafe or falsely labelled or improperly advertised, it would be a violation, but the fact that Company A has a proprietary of theirs, and Company B imitates it in appearance and composition, and perhaps



1 in a general way in packaging, although the wording on
2 the label must not give the impression that this is
3 made by, I guess it was Company A that had it, Company A.
4 If he doesn't do that, it is not a violation of our
5 law.

6 MR. WREN: A witness told us recently that
7 large quantities of drugs were seized by the American
8 Authorities in Hoboken, New Jersey, and the implication
9 was they were using stamps and dies to imitate products
10 for sale in Canada, and they were coming over. Did your
11 Department hear about that?

12 DR. MORRELL: Yes, we heard about it, and we
13 also heard some were shipping here, and we visited those
14 companies, and where there was anything left or any
15 evidence of it, we seized it to find out how it was
16 being sold and what the violation would be.

17 As I said, if it is a pink tablet of a certain
18 size and another pink tablet of the same size and of
19 the same composition, if properly ---

20 MR. WREN: Let me ask you this, if this is a
21 fair question, what did you do with those Canadian
22 companies who were improperly handling these things?

23 DR. MORRELL: We found very little. What we
24 found in one case we seized and destroyed. It wasn't
25 any great punishment to them because the amount was
26 insignificant. Another company that was supposed to have
27 them, we couldn't find any on the premises, so we
28 really couldn't have them. I don't know whether there
29 was another one. I think there were three.
30



1 MR. WHITE: Who were the companies?

2 DR. MORRELL: I am sorry, I don't think I can
3 tell you that, if you don't mind.

4 MR. WHITE: I think we should know about
5 that.

6 MR. WREN: People that are doing that should
7 be put out of business. Food and drugs are important
8 to people's health.

9 MR. PRICE: Would these companies be wholesale
10 companies? Would they be wholesaling them to retailers?

11 DR. MORRELL: They were selling them to
12 retailers, yes. They wouldn't be retail stores.

13 MR. WREN: But they are made available to
14 the public?

15 THE CHAIRMAN: I wonder if this wouldn't be
16 a good time to have a five-minute recess for the
17 witness.

18 ---A short recess.

19
20 THE CHAIRMAN: I may say at this point that
21 we would like to adjourn about ten minutes after twelve,
22 Mr. Rice, and if you are not concluded we might then
23 be able to return at 2.15.

24 MR. RICE: Dr. Morrell, still dealing with
25 this question of inspection and testing and so on,
26 there are provisions now in the Act, are there not,
27 for record control systems? Would you explain that
28 to the Committee?

29 DR. MORRELL: Under the authority given to
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2 inspectors -- I think it is called power to inspectors --
3 we can see the records of a manufacturing company or
4 of a retail establishment, or I presume, a wholesale
5 establishment. If we have reason to -- a reasonable
6 cause for looking at them because we think there has
7 been some violation of the Act or regulations, we
8 have the right to look at these and to make copies
9 of these if it is thought reasonable that they will
10 help us in the enforcement of the Act, and also in
11 our regulatory powers we have a right to demand that
12 certain records be kept and certain forms be devised.

13 MR. RICE: Are those records peculiar to
14 the manufacturers or to the retailers or are
15 wholesalers and other persons handling drugs also
16 required to keep records for your inspection?

17 DR. MORRELL: For example, in handling
18 prescription drugs, drugs that are required to be
19 sold only on prescription by pharmacists, he has to
20 keep a record of his prescriptions. We have the right to
21 examine those records, so that it goes down to the
22 retailer in that case as well as to the manufacturer.

23 MR. RICE: What about the situation where
24 the drug is in the hands of a medical doctor or
25 dentist who is dispensing it to the public? Is he
26 advised to keep any records for your inspection?

27 DR. MORRELL: No.

28 MR. RICE: Are there any inspections of the
29 doctors' facilities to store drugs?

30 DR. MORRELL: None.



1 MR. RICE: Or dentists?

2 DR. MORRELL: No.

3 MR. RICE: Or other persons that are prescribing
4 drugs?

5 DR. MORRELL: No, nor veterinarians.

6 MR. RICE: Incidentally, those are the
7 three classes of people that are permitted to prescribe
8 drugs, are they not, medical doctors, dentists and
9 veterinarians?

10 DR. MORRELL: I don't think we mention
11 them in those terms, but we say anyone who is allowed
12 to practise medicine may prescribe drugs. At least,
13 that is put back I think on the Provinces, Mr. Rowntree,
14 as to who is allowed to practise medicine or prescribe.

15 THE CHAIRMAN: The licence --

16 DR. MORRELL: Yes, under the licence provision
17 of the Pharmacy Act, the physicians and surgeons
18 and the medical practice, and so on, but this is a
19 Provincial matter as to whom may write prescriptions
20 and who may sell them, as a matter of fact.

21 MR. RICE: I believe you have already explained
22 to the Committee the way in which you enforce your
23 findings. What happens if there is a dispute between
24 you and the person that you are involved with?

25 DR. MORRELL: Well, there are many ways in
26 which the disputes are settled. If it happens to be
27 a manufacturer, he is of course entitled to come and
28 argue the matter with me or with my colleagues in the
29 Food and Drug Directorate, and I might say a good many
30



1 disputes are settled at that level.

2 He is also, I presume, entitled to see the
3 Minister, and if all else fails and it goes to Court,
4 he is entitled of course to present his case to the
5 judge or magistrate, and as far as I know these are
6 the three ways in which the disputes are settled.

7 MR. RICE: Dealing with this inspection and
8 examination, how many inspectors and examiners have
9 you, particularly with reference to the drug business?

10 DR. MORRELL: Well, we have about 70 field
11 inspectors in Canada. Then there are people who are
12 called inspectors in our headquarters staff in
13 Ottawa who are really not in the field, but do examine
14 labels and advertising of drugs and pharmaceutical
15 products. I would say there are maybe eight or ten
16 of them.

17 MR. RICE: Now, Doctor, would you explain
18 to the Committee the provisions of Section 12 and 13
19 of the Act. That is, the powers of the Minister to
20 set the requirements for the manufacture of certain
21 drugs, and also requirements of new drugs when the
22 batch must be tested before it can be marketed?

23 DR. MORRELL: Well, in Section 12 I think
24 I have explained a little about it already, in that
25 that provides authority to the Minister to set down
26 certain requirements that must be met by the manufacturer
27 before he may be permitted to manufacture drugs listed
28 in Schedule C.

29 If you look at Schedule C they consist of
30



1 liver extracts of one kind or another, insulin, certain
2 hormones such as pituitary extracts and radioactive
3 isotopes.

4 If you look at Section D you see in that
5 list living vaccines for oral or parenteral use.
6 For example, one would be VCG vaccine for TB. Drugs
7 prepared from micro-organisms or viruses for parenteral
8 use. Diphtheria toxoid. Sera and drug analogous thereto
9 for parenteral use, and antibiotics for parenteral
10 use.

11 "Parenteral", we have it defined here.
12 It means really by injection.

13 These people preparing drugs in this category
14 must meet certain requirements, and actually they
15 are inspected, as I told you, their staff facilities,
16 their records, the whole thing has been inspected and
17 if it is satisfactory, they receive from the Department
18 a licence to manufacture a product. If they want
19 to expend the product, they have to have each product
20 listed by name on the licence.

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24 Page 900 follows.
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1 DR. MORRELL: They are not licenced therefore
2 to manufacture any product in Canada, but it must be
3 licenced. Now that is, as I have said, an excellent
4 means of control and I think it works very well.

5 Now if you look at Section 13:

6 "No person shall sell any drug described in
7 "Schedule E unless the Minister has, in
8 "prescribed form and manner, indicated that the
9 "batch from which the drug was taken is not
10 "unsafe for use."

11 If you look at Schedule E you see the organic arsenicals
12 and one other type of product, that is sensitivity
13 discs and tablets. The organic arsenicals are becoming
14 much less important in therapeutics than they were
15 a few years ago because of the advent of the antibiotic.
16 The sensitivity discs are really discs that are
17 saturated with antibiotics and are used for the diagnosis
18 -- not for the diagnosis but in deciding a therapy
19 that must be given to people who are suffering from
20 infections, and from our experience we consider it
21 advisable to have these products added to Schedule
22 E.

23 Now this means, Schedule E means that each
24 batch of each product from each manufacturer who wants
25 to sell one of those in Canada must be sent -- a sample
26 must be sent to Ottawa and it must be tested there
27 and it must meet the requirements that we have set up be-
28 fore the batch may be released. The manufacturer hangs
29 onto the batch until he hears from us that he may sell.
30



1 Now this is mandatory in cases of these products
2 that are listed.

3 MR. RICE: What is the size of a batch?
4 Is there any definition of a batch?

5 DR. MORRELL: Well a batch may be big or
6 small, of course, depends on the size, what it is,
7 and the size of the company.

8 A batch is something that a manufacturer
9 has made up from a formula, in a certain way from raw
10 products, and is processed at one time. That may be
11 split up into lot numbers. Now we want to know the
12 batch number in case -- any lot number in case anything
13 goes wrong we know which day's run or portion of the
14 day's run is at fault. The rest in other batches,
15 other lots may be all right but we want to be able
16 to trace that batch in the manufacturing process and
17 in the sales end of it. If we hear that there is
18 a batch causing harm, we might want that to be
19 recalled -- we would want that to be recalled from the
20 market.

21 MR. WHITE: If you were sent one tablet out
22 of a billion would that fill a requirement?

23 DR. MORRELL: No, sampling is another problem.
24 It is a very complicated problem and I mean that
25 really because it is under discussion at both National
26 and International levels when you need to know how
27 are you going to be sure that you have got a representa-
28 tive sample. It is quite a matter but we have a division
29 in our laboratory which is a division of biometrics and
30



1 we have three people there who are basically mathematicians
2 with post-graduate work and experience in biometrics,
3 which is the measurement of -- statistics of living
4 material and they are able to advise us of what is
5 a proper batch. I don't know where we would be without
6 them sometimes.

7
8 MR. RICE: There are requirements of the
9 sample relative to the batch, and size of batch?

10 DR. MORRELL: Yes.

11 MR. RICE: And I believe you have already
12 told the Committee about the new drugs coming in, and
13 the requirements of the Minister in connection with
14 those drugs. Now Doctor having regard to the Directorate
15 and the control it has on the industry, could it be
16 said that the manufacturers of drugs in Canada are
17 all reputable manufacturers?

18 DR. MORRELL: May I say this: what I am
19 trying to point out in the beginning, the law of course
20 does not guarantee that there shall be no crime and
21 we cannot guarantee that there shall be no crime
22 or violations under this law. All we can do is hope
23 to catch them with sufficient frequency that it won't
24 be profitable so I don't think I would like to say
25 anything more than that.

26 There are a great many manufacturers in
27 Canada who are reputable and we know them because of
28 our experience. We know who is who and what is what
29 and there are some, I must say, that we need to pay
30 a good deal more attention to than we do to others, and



1 we do.

2 MR. RICE: Doctor these provisions for
3 inspection and operation of your Directorate, they
4 relate to all drugs whether a brand name or generic
5 name or whatever name they are known by?

6 DR. MORRELL: Yes, that has nothing to do
7 with our interest. We are interested in each and all
8 of them.

9 MR. RICE: Having that in mind, I want
10 to put to you a question that has been put sometime
11 before, and that is: are drugs that are sold under
12 brand names necessarily of superior quality to similar
13 drugs sold at lower prices, and does the operation
14 of the Food and Drug Act and Regulations ensure the
15 minimum standard of quality for all drugs offered for
16 sale in Canada?

17 DR. MORRELL: As I say, we do not guarantee
18 anything. Secondly, what is to prevent anybody, or
19 anybody who wants to from getting or registering a
20 brand name? I don't know what there is to prevent
21 anybody from registering a brand name, whether he has
22 the proper control facilities or has not got the proper
23 control facilities, So far as I know, and I am subject
24 to correction, the registering of a brand name does
25 not require that you have the proper control facilities
26 for manufacturing that particular brand of drug, or
27 that particular kind of drug, so that the brand name
28 in itself, to me, does not mean much and I think people
29 are galloping around shouting about brand names when they
30



1 do not realize what the inference is.

2 To me, what is important is the manufacturer's
3 name. If I know who has manufactured that particular
4 drug, I will know quite a bit about it.

5 MR. WHITE: That is my point. May I interject
6 now with a question here? Some doctors are prescribing
7 by generic name now in the hope that the druggist
8 will supply the least expensive brand in that category.
9 We have learned from the pharmacist that is not
10 necessarily the case. Most doctors continue to prescribe
11 by brand names or manufacturer's name because they
12 contend that in so doing they will get the product
13 of a reputable firm, as you have just mentioned, and
14 that if they fail to satisfy by brand name or manufact-
15 urer's name they are likely to get a product that
16 is not pure enough or strong enough or, in some other
17 way fall short of their requirement. Now then, if
18 I can stay on this point for just a minute, we were
19 informed that the Ontario Department of Health is
20 now calling for tenders by generic name. In order to
21 ensure that the drugs supplied are actually up to
22 the specifications, they have had to set up a division
23 of the Attorney General's Laboratory to test the
24 drugs which are supplied to the hospitals. This indicates
25 that the Food and Drug Act may not be strict enough
26 or it indicates that the inspection services available
27 may not be thorough enough or something of that sort,
28 it seems to me Doctor. Could you comment on that?

29 DR. MORRELL: Well if I must, I say that I
30



1 think we are doing as good a job as we can with
2 the facilities available to us. Secondly, I do not
3 think there have been any disasters in Canada. I am
4 not saying that this is due to Food and Drug, not
5 entirely; partly due to Food and Drug.

6 Thirdly, I don't think that Food and Drug
7 which is paid for by the tax-payers should be a control
8 laboratory for all the drug manufacturers that are
9 selling their products in Canada. If it were, it
10 would have to be many, many times the size it now
11 is, and it certainly would relieve the manufacturers
12 of responsibility which I think is properly theirs.
13 Our efforts have been to try to drive back to the
14 manufacturer the responsibility that I think is rightly
15 his. If he is manufacturing the drug, it is his
16 responsibility to see that it is safe and efficacious.
17 Now having said that, if I were buying drugs I would
18 possibly buy by generic name, but I would certainly
19 want to know who made that drug.

20 MR. BRYDEN: Is it not true Doctor that
21 the manufacturer's name must appear on the drug?

22 DR. MORRELL: Yes, indeed.

23 MR. BRYDEN: I mean on the package, label?

24 DR. MORRELL: Yes.

25 MR. WHITE: Why would you want to know who
26 manufactured it? If the Act is tough enough and if
27 the inspection service is broad enough why would you
28 have to know the manufacturer?

29 DR. MORRELL: Well may I answer that this
30



1 way: that if I did not know anything about the manufacturer
2 I would want the Act to do just what you say it
3 does, to analyse every batch of every drug that is ever
4 put on the market. Then I would know at least someone
5 competent has done that.

6 MR. WHITE: Surely there is a way of solving
7 this problem. You mentioned during your testimony
8 that such products as the Salk vaccine are produced
9 only by licensed manufacturers but that certain pharma-
10 ceutical manufacturers were not necessarily licensed.

11 Perhaps the solution of the problem is
12 to license all drug manufacturers and ensure that
13 the products of all manufacturers in Canada is up
14 to an acceptable minimum standard.

15 DR. MORRELL: Well that is an act I think
16 of government policy which I do not feel that I should
17 comment on.

18 MR. BRYDEN: What would be advisable, from
19 an administrative point of view and you may not be able
20 to comment on this either, but I can see the impossibility
21 of your Commission or anyone else examining every
22 batch of drugs; if there was some procedure whereby
23 some public agency assured or satisfied itself that
24 the control procedures were proper, that would seem
25 a less difficult administrative problem and might solve
26 the problem?

27 DR. MORRELL: Yes. I agree with you Mr.
28 Bryden. I think that would be helpful.

29 MR. WHITE: Doctor you mentioned that you would
30



1 want to know the manufacturer if your doctor prescribed
2 a drug for you by generic name.

3 DR. MORRELL: Well I don't think I would
4 bother him but I would hope he did. If I were buying
5 it, I would like to know the manufacturer, yes.

6 MR. WHITE: So this would confirm too the
7 stand taken by the Ontario Department of Health who
8 insists that their own laboratory, rather the Government
9 Laboratory tests products that they are buying.
10 If this is the case then there must be drugs being
11 sold in Canada that would not be acceptable to the
12 Ontario Department of Health and which would not be
13 acceptable to yourself as a consumer.

14 DR. MORRELL: I would say there may be.
15 I have always said that we do examine, and we spend
16 a lot of time on the these people who we think
17 have not the control facilities -- certainly not the
18 best, and we have taken action, seizure action and
19 other action against those companies. So far as we
20 know, we have never permitted a drug to be sold in
21 Canada that we knew was unsatisfactory in any way.

22 MR. BRYDEN: This started really from a
23 discussion of brands, and I would just like to be clear
24 in my own mind on that question, in view of some
25 quite common publicity that was given a statement by
26 you, erroneously I believe -- at least you were erroneously
27 quoted, as I understood by the prominent correction
28 that appeared next day but the brand name itself is
29 not, as I understand it, a guarantee of purity or potency
30



1 or general quality of the drug?

2 DR. MORRELL: No, because I don't know what
3 is to prevent anybody from getting a brand name.
4 If there is some way of preventing a man from getting
5 a brand name for a product that is unsatisfactory,
6 I would like to know, but I don't know. But the
7 fact that a man sells a product under a brand name
8 is no guarantee, in my mind, that it is satisfactory.
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2 Now, I must say as a consumer that I often
3 buy brands, but it is always with the knowledge it is
4 connected with a company that I know. I might buy
5 a General Electric refrigerator which has a fancy name,
6 perhaps, but I always know something about what is at
7 the back of it. When I go to drugs, well, it would
8 depend a little on the purpose for which I was buying
9 the drug. If I was buying just for a casual headache
10 I wouldn't be as fussy as I would be if I was buying
11 drugs for some life or death matter. But surely
12 people should be interested in knowing who makes what.
13 You do in your clothes, automobiles, or goods,
14 electrical appliances, and so forth, and I think that
15 is the case with drugs.

16 MR. WHITE: If you get a prescription
17 in the drug store you don't know the manufacturer.

18 DR. MORRELL: No, you are in the hands
19 of your manufacturer.

20 MR. BRYDEN: So a brand name is an
21 emotional device rather than the protection of the
22 public. It would be a case of familiarizing yourself
23 with your doctor and the name of the manufacturer.

24 DR. MORRELL: I think he does. I used to
25 see a certain drug with a generic name, but you knew
26 who made it, and if he prescribes a brand name he knows
27 who made it.

28 MR. BRYDEN: But what he may not know is
29 how much is charged for a particular brand he prescribes,
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2 and there may be another one as satisfactory which may
3 be available at a lower price.

4 DR. MORRELL: It could be, certainly.

5 MR. WHITE: Has there been any thought
6 given to the licensing of all drug manufacturers?

7 DR. MORRELL: You mean by me or by the
8 Minister? I have thought about it, we have talked
9 about it, discussed it, but this is certainly a matter
10 of government policy.

11 MR. WHITE: Have any representations been
12 made through the government to license them? Has the
13 medical profession ever made that request?

14 DR. MORRELL: Not to my knowledge.

15 MR. WHITE: Is the matter under consider-
16 ation now?

17 DR. MORRELL: No, I don't think so.

18 MR. WHITE: You mentioned field inspectors.
19 Are they all concerned with the drug part of it?

20 DR. MORRELL: No, food, drugs, cosmetics.

21 MR. WHITE: Does the same inspector look
22 after both foods and drugs?

23 DR. MORRELL: Not necessarily. Here in
24 Toronto, and certainly in Montreal, we have people
25 we are training and have trained in these two cities
26 at least to be specialists in drug plant inspection
27 and in drug manufacture. But we have one in the food
28 field, too, in these two cities, because a great deal
29 of the drug manufacture is carried on in the areas of
30



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2 Toronto and Montreal. The average inspector would
3 not be sent into a drug plant to make a specific report
4 on which he may take action. He may go into to
5 check something to see whether that has been done which
6 was recommended, but I don't think he would be sent
7 in to do a final or decisive inspection.

8 MR. WHITE: What is the share of the work
9 being done by the inspectors in the drug part?

10 DR. MORRELL: Well, I did a little
11 calculation. I can't give it to you in man hours,
12 if that is what you want, but I did a little calculation
13 for an address which I gave last August in Saskatoon.
14 It would be about five-elevenths of the total time on
15 food and drugs is spent on drugs. I did that by
16 estimating from total time studies, that the food and
17 drugs cost Canadians about eleven cents per person per
18 year, and I figured the amount spent on drugs was
19 about five cents per person a year in Canada.

20 MR. WHITE: So the work of thirty-two men
21 represents drugs in that?

22 DR. MORRELL: Well, in that five cents and
23 eleven cents there is the laboratory work, too, which
24 I think you would be interested in in this figure,
25 and some of that is rather expensive in that it
26 requires expensive equipment, and all of that must be
27 taken in.

28 MR. WHITE: You say thirty-two inspectors'
29 time is spent on drugs?
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DR. MORRELL: No.

MR. WHITE: Is there any inspection at the wholesale and retailing level?

DR. MORRELL: Yes.

MR. WHITE: And would most of the inspecting be done at the manufacturing level?

DR. MORRELL: Most of it.

MR. BRYDEN: On this point, Mr. Chairman, one further point. I understand your Directorate has found that enforcement with regard to drugs which are not in accordance with the terms of the act, quality, and so on, -- the most effective measure of enforcement is seizure rather than prosecution. Could you give us a number of instances you have found it necessary to seize drugs, giving whatever period is convenient?

DR. MORRELL: I have it here somewhere.

MR. BRYDEN: Perhaps you could look at it over the lunch hour.

DR. MORRELL: It shouldn't be difficult. Yes, I have it now. Sixty-three times in the last fiscal year.

MR. BRYDEN: That would be ending last March 31st?

DR. MORRELL: Yes.

MR. BRYDEN: Sixty-two times?

DR. MORRELL: Sixty-three.

MR. BRYDEN: Would you have a breakdown



1
2 as to how many of those instances were drugs domestically
3 manufactured and how many were seizures at the border
4 and at customs offices?

5 DR. MORRELL: These are all domestic,
6 Mr. Bryden, because we don't seize at customs, we just
7 say it can't come in.

8 MR. BRYDEN: Would you have a figure as
9 to how many you stopped from coming into the country?

10 DR. MORRELL: That I don't know. These
11 were gotten together when we were asked on constitutions
12 and seizures and other legal action. They were gotten
13 together for that purpose. I don't know whether I
14 have the refusals of entry. It may be possible to
15 get them, but I don't think I have them here.

16 MR. WHITE: Would you tell me how many
17 of the sixty-three seizures were from manufacturers?

18 DR. MORRELL: I think these were all from
19 manufacturers. We very seldom seize from a wholesaler
20 or retailer.

21 MR. WHITE: Could you tell us further if
22 most of the seizures were limited to a small number
23 of manufacturers?

24 DR. MORRELL: Well, I have them in detail,
25 but it would take some time to add them up.

26 MR. WHITE: Could you file that?

27 DR. MORRELL: I would rather not, sir.
28 Names are given.

29 MR. WHITE: Could you tell us after lunch
30



1
2 hour if company A, for instance, had twenty-five
3 seizures and company B, and so on?

4 DR. MORRELL: Well, I can if I have them.
5 I could make a table of them. I see one appears twice
6 on page 1. All the rest are singles. There is the
7 one who appeared twice on that page is at the top of
8 the third page. There is another fellow twice, there
9 is another fellow one who has twice, another one four
10 times. Here is another one that has three times. This
11 is the way they go. There is another one, three more
12 to that fellow who was four, which makes seven times.

13 MR. WREN: How many of those infractions
14 of the Act would be knowledgeable, and how many would be
15 innocent? In other words, intentional, that they had
16 knowledge they were doing the wrong thing?

17 DR. MORRELL: That is pretty hard to say.

18 MR. WREN: For example, you quote one
19 instance there where this company was involved seven
20 times. Would it be in the same process?

21 DR. MORRELL: Here is one whose tablets
22 were quite a way above the declared potency. I don't
23 think he knew that. I think that was bad control or
24 ignorance.

25 THE CHAIRMAN: If the potency of a pre-
26 paration was not as stated, it would be a highly
27 dangerous situation.

28 DR. MORRELL: Some of them, if they are
29 high, can be even more dangerous than if they are low,
30



1
2 and this one I thought was getting into the dangerous
3 stage. Instead of saying your so and so tablets
4 are 125 per cent potency, they were too high for that,
5 and we went and seized them and destroyed them.

6 MR. BRYDEN: I presume there is some margin?

7 DR. MORRELL: The tolerances are laid down
8 in the regulations for most cases. You have to allow
9 a certain tolerance for manufacturing reasons; even
10 good manufacturing factors cannot make them identical.
11 A little variation is permitted, depending on the
12 kind of tablet.

13 MR. WHITE: That instance you mentioned,
14 was that discovered because it was in the category of
15 a drug that must be sampled?

16 DR. MORRELL: No, that was discovered
17 because this man, we thought, did not have adequate
18 controls and we were camping on his tail. That is why
19 we got seven.

20 MR. LAVERGNE: Mr. Wren was asking about the
21 knowledgeable infractions. In most cases -- I am
22 using a term perhaps a lawyer would use -- they were
23 first-time offenders or at least offenders only one time.
24 But as the potency of a drug is increased, then as a
25 layman is it logical to assume that the cost of that
26 drug to the manufacturer would be increased? I mean,
27 he wouldn't do it intentionally.

28 DR. MORRELL: I don't think that would
29 necessarily follow, sir. The next batch might be low
30



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2 enough to make up for what he lost.

3 MR. BRYDEN: Your powers are given under
4 Section 21 (1)(d). Is that the section under which you
5 act?

6 DR. MORRELL:

7 "seize and detain for such time as may be
8 necessary any article by means of or in
9 relation to which he reasonably believes
10 any provision of this Act or the regulations
11 have been violated."

12 MR. BRYDEN: That is the clause you
13 operate under for seizure?

14 DR. MORRELL: Yes.

15 THE CHAIRMAN: I think this will be an
16 appropriate time to adjourn, and we will resume at
17 2.15.

18 --- Adjourned for luncheon.
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1 THE CHAIRMAN: Are we ready to proceed?

2 MR. RICE: Before we had our recess I
3 believe you were explaining to Mr. White and Mr. Bryden
4 about how you would rely on certain manufacturers
5 in the production or purchase of certain drugs?
6

7 I want to now recap the types of drugs that
8 are under the jurisdiction of your Directorate. We
9 have already covered drugs under the Proprietary Medicine
10 Act. These are the drugs that can be advertised and
11 sold almost anywhere, and then under the Food and Drug
12 Act I understand there are two classes of drugs under
13 this Act; one class of drugs that cannot be advertised
14 but can be sold, and then there is another class of
15 drugs that also cannot be advertised but the sale is
16 restricted to prescriptions; is that correct?

17 DR. MORRELL: Yes, that is true. Yes, you
18 are right in all cases so far.

19 MR. RICE: Now then, we move on to this
20 prescription list, if you could explain to the Committee
21 the reason for certain drugs being listed on a pres-
22 cription list.

23 DR. MORRELL: Well, Mr. Rice, it is essentially
24 of course a public health matter. You will note if you
25 look at the list which is given in Schedule F there
26 are a variety of drugs on there. They are not necessarily
27 related to one another, although certain groups and
28 classes of drugs are included almost entirely.

29 The purpose of course for putting them on
30 there is so that they may legally be purchased or can



1 legally be purchased only on the order of a doctor
2 or dentist, or one who is licensed by the Province
3 to prescribe. This is intended, of course, as a
4 matter of protection to the public. Now, why some
5 of them are on and not others is a question of
6 administrative policy of what should go on.

7 This has been discussed, of course, with
8 the Canadian Medical Association representatives, and
9 the Canadian Pharmaceutical representatives. As a
10 matter of fact, we have a standing committee consisting
11 of one representative of the C.M.A., that is the
12 Canadian Medical Association, and one representative
13 of the Canadian Pharmaceutical Association, who advises
14 the Department on what drugs should be included in
15 this list.

16 Now, as a guide to them, we have set up a
17 few principles which help in deciding. A drug is
18 not necessarily put on this list solely for its
19 toxicity. Most drugs themselves if improperly used
20 are dangerous. One of the main reasons for including a
21 drug on this list is the situation where it is either
22 abused or misused by the public. I suppose we put
23 most all of the tranquillizers and the sedatives on
24 the list for this purpose. If taken rationally and
25 normally they are not particularly harmful drugs. They
26 can, however, become through constant use a habit-
27 forming drug, and they are used for conditions that
28 are common or supposed to be common in the world today,
29 anxiety and sleeplessness, and so they have become
30



1
2 drugs which do present a public health problem, and
3 therefore they were put on the prescription list.

4 Other drugs are on here for other purposes.
5 Again, it can be related to misuse and abuse. There
6 are a few, perhaps, that are on here because of a
7 specific danger. They might be used improperly in a
8 dangerous situation by the public if they could get
9 them over the counter and treat themselves.

10 These are the main principles that we follow
11 in putting a drug on this list. Some of the drugs
12 on this list themselves are not the most dangerous and
13 the most poisonous ones, but they have been used or
14 misused in such a way that it is desirable that their
15 sale be controlled by prescription and proper medical
16 advice.

17 I don't know whether I have covered the
18 ground you want or that you are thinking of, Mr. Rice.

19 MR. RICE: Yes, I think you have covered
20 the ground very well. I wanted some explanation to
21 the Committee, and I wanted to bring out the point
22 that drugs are not put on the list necessarily because
23 they are dangerous. There are dangerous drugs that are
24 not on the prescription list; is that correct?

25 DR. MORRELL: That is correct. I think you
26 won't find many drugs that are given only by injection
27 that are on here, because we feel this is not necessary
28 because most people are not anxious to inject themselves
29 and they go to a doctor for it, so we haven't felt it
30 necessary to put on injectable drugs although



1 they themselves are dangerous.

2 MR. RICE; Now, the labelling of drugs;
3 we dealt with the labelling under the PPM Act. What
4 are the requirements for labelling drugs under the
5 Food and Drug Act?

6 DR. MORRELL: Well, some of them are rather
7 extensive, and I will refer to the regulations.
8 There is a section in the regulations that deals with
9 labelling in general.

10 THE CHAIRMAN: What section is that?

11 DR. MORRELL: Section C.01.004 at page 76
12 in the blue pages. The blue pages are drugs, and
13 yellow pages are foods and pink pages are vitamins,
14 and the green are cosmetics, and so on.

15 Now, in Division 1, that is C.O. of
16 Part C, there is a section 004 which provides for
17 labelling of drugs in general. When you come to
18 specific drugs which will be mentioned in a specific
19 part of the regulations that follow this, you will
20 find specific requirements that might be in addition
21 to these. However, these are the main requirements, I
22 think.

23 Now the first one is the proper name or
24 the standard name under which a drug is manufactured
25 shall be on the label, and when there is a Canadian
26 licence number, of course it shall be on, and if there
27 is no proper name, the common name. That is, on the
28 main panel, on both inner and outer labels; the name
29 of the manufacturer or distributor; the address of
30



1 the manufacturer or distributor except where the con-
2 tainer has five millilitres or less, the statement
3 may not be made on the inner label. That is simply a
4 convenience because the label becomes rather small, and
5 if it is on the outside of the package, it is all
6 right.
7

8 Where a drug is intended for internal or par-
9 enteral use, the lot number. There must be a lot
10 number on those because there are specific dangers
11 connected with them. Adequate directions for use --
12 that might be the dosage, and whether it is for injec-
13 tion or application or to be taken by mouth, or whatever
14 it is.

15 The proper, or if there is no proper name,
16 the common name must be contained and show each
17 medicinal ingredient contained therein except on the
18 shipping cases or official drugs. Now, official
19 drugs are those that are listed in the Pharmacopeia
20 and they will be labelled according to the Pharmacopeial
21 name.

22 Drugs sold on prescription -- well, it is
23 obvious that the doctor in many cases at least does
24 not want the patient to know what drug he is getting,
25 and I think that is a good thing, so we don't insist
26 that it be put on the prescriptions.

27 Medicines throughout the PHM Act, as I say,
28 they have special labelling requirements of their own;
29 on the outer label net contents in the terms of weight,
30 measure or number, and whether a drug is intended for



1 parenteral use-- that is, by injection. The name and
2 portion of any preservative contained therein.

3 Those are the general requirements for the
4 labelling of drugs. As I said before, there are
5 specific requirements for specific drugs. Now, you
6 will notice that the proper name -- that is, in
7 terms of these regulations -- is really a generic
8 or non-proprietary name. We use the term "proper name"
9 for it.

10 MR. RICE: Thank you. Having regard to
11 those duties that you have explained to the Committee
12 that is imposed upon your Directorate, has the
13 Directorate the facilities and staff adequate to carry
14 out those duties?

15 DR. MORRELL: Well, we have fairly good
16 facilities, but we haven't enough staff. The answer to
17 the latter part of your question is we have not enough
18 staff, but our facilities are reasonably good.

19 MR. WREN: Is that because of finances or
20 unavailability of trained people?

21 DR. MORRELL: That is a matter of government
22 policy. To answer your question it is partly due to
23 lack of trained people. We have two vacancies, or is
24 it three -- certainly two -- in our Ottawa laboratory
25 for pharmacologists, and there are not any who are
26 willing to come and work for the salaries we offer,
27 and these have been vacant for over two years, so
28 it is not a temporary thing.

29 MR. WREN: Vacant three years?
30



1 DR. MORRELL: Over two.

2 MR. WREN: You haven't been able to fill them?

3 DR. MORRELL: No. They have been advertised
4 four or five times, and we have been in communication
5 with people that we hear about, but we haven't got them
6 filled yet.

7 MR. BRYDEN: What limitation does that
8 impose on your activities? Is it a matter that it
9 takes you longer to do things or certain activities
10 you would like to undertake are not undertaken?

11 DR. MORRELL: Well, perhaps a little bit of
12 the latter, but mostly of the former. It takes us
13 longer to do things that we are doing, but we just don't
14 get over as much in a year as we would if we had more
15 staff. A little bit of the latter because, for
16 example, there are two vacancies -- at least I think
17 there is a third one -- of specialists. We won't
18 be able to do certain kinds of work in that field, in
19 that section of the laboratory because we have not
20 got these people. We just haven't got them.

21 MR. RICE: Dr. Morrell, in carrying out the
22 work of the Directorate, the inspection and examination
23 work, are there any examinations or tests carried out
24 as a result of complaints received from the public?

25 DR. MORRELL: Yes. Complaints are one
26 source of our information. We always investigate
27 complaints whether they come from the public or hos-
28 pitals or doctors or competing pharmaceutical firms.
29 I think in view of the staff situation it is a very
30



1 important source of information for us. Some of it,
2 of course, leads nowhere, but some of it does lead us
3 to something that is worthwhile investigating.

4 MR. RICE: Can you tell the Committee whether
5 or not the complaints have been increasing in the
6 last years?

7 DR. MORRELL: My impression is that they
8 have been increasing, but not by any dramatic amount.

9 MR. RICE: Once again, as under the PPM Act,
10 under the Food and Drug Act, has the Directorate any
11 control or any connection with the price of drugs?

12 DR. MORRELL: No, we have in no way any
13 connection with the price.

14 MR. RICE: If a new company is going to
15 manufacture drugs, how is your Department usually
16 advised of this?

17 DR. MORRELL: Well, it depends. If it is
18 going to manufacture licenced products, they must
19 apply for a licence; if they are going to manufacture
20 proprietary or patent products, they must apply for
21 licence and registration. In other fields we are
22 not necessarily notified at all. It is up to our
23 inspectors or our organization somehow to find out
24 that Smith and Company has started business.

25 MR. RICE: Doctor, having regard to your
26 close association with the drug business, can you
27 or would you be able to suggest any way or steps
28 to the Committee that could be taken to reduce costs
29 of drugs?



1 DR. MORRELL: No, I don't know how to do it.

2 MR. RICE: Mr. Chairman, unless the Committee
3 has any further questions from Dr. Morrell, I submit
4 it has been very extensively covered in the submissions
5 from the Directorate.

6 MR. WHITE: Dealing with imported drugs,
7 Dr. Morrell, there are some classifications of drugs
8 which are made in Canada only under licence. You
9 told us that earlier.

10 DR. MORRELL: Yes, or sold in Canada .

11 MR. WHITE: That is what I wanted to clarify.
12 If one of these drugs was made in some foreign country
13 and brought into Canada, would it be sold under
14 licence only?

15 DR. MORRELL: We have those drugs. We
16 have licence plants in the United Kingdom, in France,
17 in the Netherlands, in Denmark, in the United States,
18 and I am not sure whether we have in Western Germany.

19 MR. WHITE: You actually license those plants?

20 DR. MORRELL: Yes, those plants are inspected
21 by one of our people. Everything is done just as
22 if he were in Toronto or Philadelphia.

23 MR. WHITE: In that particular classification
24 of drugs, if a foreign firm were to make that drug,
25 could it be imported into Canada?

26 DR. MORRELL: Not quite, if it were not made
27 under our licence, it could not.

28 MR. WHITE: There are certain drugs which
29 you test by sample from each batch made?
30



1 DR. MORRELL: Yes.

2 MR. WHITE: In all cases, are these made
3 by licensed manufacturers only?

4 DR. MORRELL: No, there is no licence for
5 those manufacturers at all.

6 MR. WHITE: Dealing with the classification
7 of drugs that is made by a foreign manufacturer imported
8 into Canada, would you test samples from each batch?

9 DR. MORRELL: Yes.

10 MR. WHITE: The same regulations would apply?

11 DR. MORRELL: Yes.

12 MR. WHITE: Do the same labelling regulations
13 apply to imported drugs?

14 DR. MORRELL: Yes.

15 MR. WHITE: Those drugs which are just spot checked,
16 so to speak, not made under licence and not tested
17 batch by batch, would your inspectors be able to
18 test? They would not be able to test every shipment,
19 I don't suppose would they?

20 DR. MORRELL: Oh no we have not a real
21 firm figure, but we estimate there might be as many
22 as 25,000 products offered for pharmaceutical purposes
23 in the country. There might be as many as that. That
24 figure is only arrived by selecting catalogues and
25 price lists of all the manufacturers that are selling
26 in this country and the number of items, and they
27 are either reliable or unreliable depending on the
28 reliability of the price lists.

29 MR. WHITE: From your experience, would you
30



1 say that the imported drugs were as high standard as
2 drugs manufactured in Canada?

3 DR. MORRELL: Some of them are, yes. You
4 see there are all sorts of companies importing or
5 exporting to Canada, some of the very best and some
6 not so good. I would say on the whole they are as
7 good as those made in this country from our analysis
8 and inspection figures.

9 MR. WHITE: You mentioned that you were keeping
10 a closer eye on those Canadian companies that you
11 have reason to suspect did not have adequate controls.
12 Would it be likewise true with the foreign companies
13 whose reputations are not quite as good? Are they
14 watched more closely?

15 DR. MORRELL: Yes, we have some knowledge
16 that foreign firms -- the last spring for example,
17 we had one of our best and perhaps most experienced
18 and the better trained inspectors worked in Europe for
19 five or six weeks. He had not the authority to demand
20 the facilities, but he visited a great many manufacturers
21 and different companies in Europe, and he was shown
22 from courtesy or just plain good business sense with
23 facilities in these companies.

24 We did get from him a report about his
25 trip that gave us a fairly good background of those
26 companies whom he had seen.

27 We have had other visits to Europe, perhaps
28 not so thorough or comprehensive that gave us knowledge,
29 and we get information from other people in other ways.
30



1 The European manufacturer, outside of the
2 United Kingdom -- and the United Kingdom is a special
3 case -- is not totally unknown to us. We know quite
4 a number of firms and what to expect of them. Once
5 again, under the circumstances all we can do is to put
6 most of our time and attention on those where we
7 suspect it is most needed. This is what we do and it
8 is what we will always have to do, I presume.

9 MR. WHITE: In Canada, if a drug manufacturer
10 makes a bad batch and pays a penalty, you can do that.
11 But what can you do about imported drugs? All you can
12 do is reject them?

13 DR. MORRELL: We can say, "You have an
14 alternative." There is an importer as well as an
15 exporter. We can say that this lot of this drug may
16 not come into Canada. He can either re-export it
17 back as to his principals, or wherever else he feels
18 that he can sell it, and if not we will destroy it.

19 MR. WHITE: The penalty is in there, because
20 you can just divert the shipment.

21 DR. MORRELL: Yes, if you can divert. I
22 would not always be sure, but mostly you can divert it.

23 MR. WHITE: It was reported to me indirectly
24 from a pharmacist, and I can hardly believe the story,
25 but I will tell it to you. A shipment of drugs from
26 Europe was sent into New York was rejected by some
27 agency of the government, and was then diverted to
28 Montreal where the shipment was unloaded and the drugs
29 sold in Canada. Does that sound right to you?
30



1 DR. MORRELL: I would not say that it did
2 not happen because I do not know. I cannot say that
3 it has never happened in history, but I think I can
4 say this -- I do not know whether there are any
5 Americans on the Committee but I don't care -- I think
6 our control is as good as or better than the Americans.

7 After having said that, I will not say this
8 did not happen because it could happen somehow or
9 other. If he knows it happened, it happened. That
10 is all.

11 MR. WHITE: On the other hand, I have no
12 proof that that story is correct.

13 DR. MORRELL: I would question it. In the
14 first place may I say this, too, that if the United
15 States Food and Drug Administration know that a
16 rejected lot of food or drugs have been rejected and
17 are being sent to Canada, they always tell us. They
18 phone or write.

19 MR. WHITE: You mentioned something about
20 clinical testing of new drugs and said also that
21 the claims being made for the new drugs were investigated
22 at the same time. At another stage of your testimony
23 you said no check was kept on the advertising claims
24 made by drug manufacturing companies to doctors.

25 DR. MORRELL: Well, no. Did I say that?

26 MR. WHITE: I thought I heard that.

27 DR. MORRELL: I must correct it. We observe
28 it. We watch it and we read it, but if we see something
29 that is really silly or absurd or false, we do not
30



1 prosecute the manufacturer, but we know what they
2 are saying.

3 MR. WHITE: If it were obviously untrue,
4 wouldn't you do something in that case?

5 DR. MORRELL: I don't know, yes and no.
6 When a new drug submission comes in to the Food and
7 Drug Directorate at Ottawa, it goes through a certain
8 routine and a certain number of hands, each of whom
9 has a function to perform either examining the pharma-
10 ceutical data, the manufacturing data, the labelling,
11 the proposed circulars, and the clinical testing,
12 and each one writes on a form his comments after having
13 reviewed it. It goes back to an office where it is
14 then looked after in the form of me either recommending
15 it for acceptance or rejection for certain reasons.

16 Some of those come back to me with a statement
17 that they think that the claims are justified except
18 for one or two that they feel have not been supported
19 by the data provided.

20 On the basis of that, a letter is prepared
21 to the manufacturer saying that we have reviewed
22 his data, his information, and we do not feel that
23 the claim for such and such is justified by the infor-
24 mation submitted. We cannot release that or say that
25 he may sell it in Canada, and if he does sell it
26 with those claims we will have to invoke Section 9,
27 I think it is, of the Food and Drugs Act which says
28 that no person shall sell a drug whose advertising or
29 labelling is false or misleading. That, of course,
30



1 would put us into court and we would have to prove
2 that this was false or misleading.

3 MR. WHITE: And under advertising would
4 you include direct mail advertising to doctors?

5 DR. MORRELL: We would with regard to whether
6 it was directed to doctors or not.

7 I would say this, that never have we had a
8 flat rejection from a company to that stand of ours.
9 They have come to us or they have modified their adver-
10 tising, or they have provided additional supporting
11 data for what they want to claim, or they have
12 simply withdrawn the claim.

13 MR. WHITE: Would there be a large volume
14 of direct mail advertising to Canadian doctors?

15 DR. MORRELL: Yes, I suppose there is quite
16 a volume.

17 MR. WHITE: Do you have any control over that?

18 DR. MORRELL: No, some I get because they
19 may think I am a medical doctor, or maybe they want
20 me to see it because of my position in the Directorate,
21 and I see the advertising for a few companies and
22 that basis only. However I presume I would only get
23 a very little of the volume that goes out.

24 MR. WHITE: Can you elaborate on the remarks
25 you made about clinical testing of new drugs? What
26 is done? I don't understand that?

27 DR. MORRELL: Let us come to a new drug
28 which is classed as a new compound or something that
29 has not been known before either in chemistry or as
30



1 to its value in medicine if it has never been decided
2 before or is totally unknown before. Some manufacturer
3 picks this up and says, "We will use it in this
4 industry."

5 First of all he has to do some laboratory
6 tests in pharmacology and toxicology. He is
7 obliged to provide us with the details of his
8 experiments on various animals, on their systems,
9 organ systems, and say something about the action
10 they have on the nervous system. Does it act on the
11 heart or on the liver or on the digestive system or
12 the enzyme system of the body? What is the fundamental
13 basis of the action?

14 Then he has to provide information on animals
15 and I would think the Commission would want to know
16 about this, on the relative toxicity if it is a
17 drug that is going to be used for a long time, anyear
18 or a lifetime. It is a different matter if that is
19 the case than if it is to be given only once or twice
20 and then it is finished.

21 He has to determine the chronic toxicity,
22 that is how much will kill anytype of animal and he
23 tries it on more than one species. When he has all
24 that information collected together, he explains
25 what it means.

26 He goes to a clinician, maybe in a hospital
27 but a clinic or someplace where there is a specialist,
28 because our requirement is that it should be done by a
29
30



1 specialist and not just by a general practitioner.
2 We do that because we feel the specialist has the
3 facilities to observe his patient and specialize,
4 to keep him in hospital under observation. He has the
5 facilities for blood counts, the facilities for cardiograms
6 or whatever it is at his disposal, and he can follow
7 that drug better than the general practitioner.
8 His purpose is to use it in the disease or disorder
9 or condition for which he is going to promote it.

10 These clinicians are required to keep a
11 close record of the diagnosis and the condition of
12 the patients before and after and their opinion of
13 the value of the drug.

14 We have no cut and dried routine that we
15 require because I think each drug would have to have
16 its own routines. So when the manufacturer thinks
17 he has enough clinical data obtained in this way
18 to support his case, he collects it together and sends
19 it to us. We may not agree with him that he has enough,
20 or we may agree that he has plenty.



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2 This is the type of thing that we refer to
3 as the clinical data. A drug is still not available
4 to the general practitioner, or perhaps to any other
5 specialist than the one that the manufacturer has
6 chosen to put in his hands for trial in specific cases,
7 and naturally the manufacturer will approach the
8 clinician that is a specialist in the particular
9 disease or class of diseases in which he is going to
10 recommend the drug.

11 MR. WHITE: An approval must be obtained
12 before that drug is sold?

13 DR. MORRELL: Yes. I don't like the word
14 "approval" but the manufacturer must satisfy the
15 Minister that it is not unsafe for the use for which
16 it is to be recommended.

17 MR. WHITE: Does the Minister have to
18 give that assurance before a drug can be given away
19 as samples for testing on a widespread scale?

20 DR. MORRELL: On a general broadcast basis,
21 yes. We wouldn't except that clinical test.

22 THE CHAIRMAN: Have you had an opportunity
23 of observing which country supplies the non-Canadian
24 made drugs which are imported into this country?

25 DR. MORRELL: From which country --?

26 THE CHAIRMAN: Which country produces
27 the most drugs?

28 DR. MORRELL: I suppose the United States.

29 THE CHAIRMAN: The United States?
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DR. MORRELL: I suppose so. I haven't got figures. I stand ready to be corrected on that.

THE CHAIRMAN: Would there be any substantial volume from Europe or Italy?

DR. MORRELL: I think a substantial volume from Europe but I don't think the majority of the European drugs come from Italy. Some of them come from France; some come from Switzerland; some come from the United Kingdom; some from Holland; some from West Germany.

THE CHAIRMAN: Any Japanese drugs?

DR. MORRELL: A few. Not many yet.

MR. WHITE: May I just clarify one other thing? You said or you mentioned that the United Kingdom drugs were in a separate category entirely.

DR. MORRELL: We know more about them. That is all. We didn't know -- we still don't know as much about the drugs made in Continental Europe except perhaps for a few countries -- Switzerland is one -- as we do about the drugs that are manufactured in the United Kingdom.

MR. BRYDEN: I would like to ask Dr. Morrell some questions about Schedule F. The drugs there, I understand, are to be sold only under prescription. My understanding is that a number of drugs that I suppose are commonly referred to as tranquilizers were added to Schedule F within the last year or two. Is that correct?



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DR. MORRELL: I think about two years ago.
Yes, about two years ago.

MR. BRYDEN: For example, if I could take one, maybe my pronunciation may be a little weird, but I think you will probably understand what I am referring to, one drug that is called Meprobamate and is sold under such trade names as Miltown, Equanil, or Neo-Tra and so on, is that one that was added fairly recently?

DR. MORRELL: It was added at the same time. Meprobamate was added at the same time, about two years ago.

MR. BRYDEN: Prior to that time was that available for sale over the counter?

DR. MORRELL: Yes.

MR. BRYDEN: And would that also mean that subject to review by your Directorate it could be advertised to the public at large?

DR. MORRELL: Yes.

MR. BRYDEN: I understand, with regard to this drug, that it was advertised as being non-addictive, but has since been found to create addiction, at least, in certain cases.

DR. MORRELL: Well ---

MR. BRYDEN: Is that correct?

DR. MORRELL: Well, technically the addiction producing drugs are the narcotic drugs and the habit forming drugs I think is another matter.

MR. BRYDEN: This would be in the habit



1
2 forming --

3 DR. MORRELL: Miltown or Equanil
4 was a habit forming drug. We put that one on on the
5 strong recommendation of the Canadian Medical
6 Association.

7 MR. BRYDEN: The reason I am inquiring along
8 this line, Doctor Morrell, it isn't that I am interested
9 in Miltown particularly, but it seems to me there is
10 a considerable degree of danger to the public in the
11 area that the preparation may not contain what the
12 label says. We have discussed that in some detail
13 this morning, how that aspect is controlled. There is
14 also the danger that it will be promoted in ways that
15 might not be very safe, from the point of view of the
16 general public.

17 DR. MORRELL: Yes, that is true.

18 MR. BRYDEN: How could the manufacturer
19 get away with saying that the drug was non-addictive,
20 as I believe he did for a long period of time, and then
21 I think he altered his claim to say that it was, at
22 least in terms, that it was suitable for a long therapy,
23 or something like that, some expression implying that
24 you could carry a patient on it for a long time.

25 DR. MORRELL: Well, I dare say patients
26 have been carried on Meprobamate for a long time too,
27 and I think that is proper and suitable under close
28 supervision, but the difficulty was by word of mouth
29 as well as by advertising by their company, it became
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2 well known to the public and everybody is looking for
3 a crutch and so they could go and buy some Meprobamate.

4 Now, they are probably not aware of the
5 difficulties if you continue to use this over long
6 periods of time. There is no one to say that you
7 shan't take two. They think that if one is good,
8 two is twice as good, and so on, and there are other
9 social things too, I suppose, gave you a sense of
10 perhaps a little bit of irresponsibility, and in
11 driving automobiles it became a problem as some of
12 these others did. It isn't only liquor you are
13 driving under the influence of, or impaired driving.
14 All of these things added together led us to believe
15 that this should be now put on prescription, and we
16 did.

17 MR. BRYDEN: When that drug was first put
18 on the market in Canada was it necessary for the
19 manufacturer to submit such clinical information as he
20 had?

21 DR. MORRELL: That was a new drug, yes.
22 It went through the mill.

23 MR. BRYDEN: But on the basis of information
24 then available, it appears to be ---

25 DR. MORRELL: Yes, it appeared to be safe
26 and not likely to produce habitation. It is difficult,
27 perhaps impossible for the first year or two to know
28 all of the side effects or consequences of the use of
29 a drug. Its safety, in general, can certainly be
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2 demonstrated but until it has been used for some time
3 you never get all the story.

4 MR. BRYDEN: There is another one I was
5 wanting to inquire about. Again my pronunciation
6 is probably off, but Prochlorperazine, which is sold in
7 Canada as Stemetil and in the U.S.A. as Compazine.
8 Was that one that was previously not in Schedule F?

9 DR. MORRELL: That was one that was put on
10 at the same time as Meprobamate.

11 MR. BRYDEN: I have seen in the statement
12 of psychiatrists that that is a pretty potent drug?

13 DR. MORRELL: Yes, there are many potent
14 drugs still that are not on prescription, and I don't
15 know that they need to be on prescription. What makes
16 them dangerous is the public begins to know about them,
17 and begins to gossip about them.

18 MR. BRYDEN: And abuse them?

19 DR. MORRELL: And abuse them, and the next
20 thing is abuse. As long as they don't know about them,
21 or are not attracted by them, there is no reason to put
22 them on prescription.

23 MR. BRYDEN: Well there are still some
24 tranquilizers that are not on the prescription list.

25 DR. MORRELL: Well of course, there are
26 tranquilizers that are not on prescription. That is
27 a term that is very loose. Alcohol is one; tobacco
28 is another. You can use a lot of things for
29 tranquilizers but if you mean a particular group of
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2 drugs, sometimes they are called ataractics, I don't
3 know that there are many that are not on the prescription
4 list. There are some sedatives that are not on.
5 I don't think they are serious because they are not
6 on.

7 MR. BRYDEN: What about the antihistamines?
8 I was noticing in this publication, which you probably
9 know of, called "Drug Index" in the issue ¹ have they
10 seem to express a little surprise that some of these
11 preparations are not in Schedule F. At any rate,
12 maybe I am misinterpreting their surprise. I will just
13 read what it says, on page 9 under the heading
14 Antihistamines.

15 "In general, this important class of drugs
16 escapes inclusion in Schedule F despite a
17 contrary practice in many other countries.
18 Even Promethazine (PHENERGAN)...."
19 Which I take is the trade name....

20 "...which is a phenothiazine derivative,
21 and which is used as part of the process of
22 anesthesia, is exempt."

23 DR. MORRELL: Well, may I go back a little.
24 Schedule F is a fairly recent innovation in the Food
25 and Drug Act. If I had to guess, it is only a guess,
26 it would probably start at about twenty years ago.
27 The intention at the beginning, certainly I was not in
28 my job in those days, I was in the laboratory, was to
29 keep the list as small as possible and only put drugs
30



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2 on there when there was specific reason for it. In
3 some countries nearly everything is on prescription.

4 In the United States I think there are more
5 drugs on prescription than there are in Canada, but
6 when I came to my present position, I reviewed the
7 whole thing and I began to think in terms of what was
8 in the public interest, and in terms of public health
9 and I couldn't see any reason for putting everything
10 under the sun on Schedule F, and we did try, and
11 successfully for some years, to keep it rather small.

12 It's growing and I think it will continue to
13 grow.

14 Now, with respect to antihistamines they are
15 still not on prescription. Of course, some of them are
16 potent but that is not the reason for putting them on
17 prescription. We have no knowledge about abuses or
18 misuse, or specific dangers that have been demonstrated
19 by misuse. Personally, I object to putting them on
20 unless we have some specific reason for it. It is
21 very easy for me to add to that list indefinitely.
22 It's a much different problem for the pharmacist or
23 even our inspectors to see that it is obeyed so that
24 my philosophy, at least, is not to make the list any
25 longer than is quite necessary.

26 MR. BRYDEN: Yes, but one problem that I
27 see noted is that you have an industry who goes in
28 for very heavy promotion, and in the specific case of
29 Meproamate they were doing a lot of advertising to
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2 build up sales, which is a natural activity for them.
3 It may have been detrimental to the public.

4 DR. MORRELL: Well, may I say something.
5 I looked into this and I had a talk with some of the
6 people, I believe it was on prescription in the United
7 States -- I don't know whether it still is -- but
8 at the time I was talking to the public relations
9 officer for the companies, I think it was and it wasn't
10 here, and he told me the dollar value of the sales that
11 would be made in the United States in that twelve month
12 period, or the estimate, and the one in Canada, and
13 although it was on prescription in the United States
14 and was not on prescription in Canada, the dollar value
15 per capita was much less here, so I don't know how
16 to account for this, but there it was.

17 MR. BRYDEN: Maybe the medical profession
18 is sometimes a little lax in its prescribing habits
19 in the United States at any rate. I have seen
20 statements to the effect that a fellow can go around
21 and pick up prescriptions for these drugs, in any case,
22 so it seems to me it doesn't make much difference
23 whether it is on the list or not.

24 DR. MORRELL: I guess it makes a little
25 difference.

26 MR. BRYDEN: Yes. Well, if I may change
27 to one or two other points, I don't believe that Mr.
28 Rice covered the question of obsolescence of drugs
29 in his examination. If he did, I won't repeat ground
30



1
2 that has already been covered but there are some
3 drugs, I believe that retain their potency for a period
4 of time which maybe a few months or a year, or something,
5 and I was just wondering if you could give us any
6 information on that; how that problem is handled by
7 your Directorate.
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9 (Page 948 follows)
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1 DR. MORRELL: Mr. Bryden, in specific cases
2 where it is a well-known fact, for example, with some
3 antibiotics which deteriorate with time, we require
4 the manufacturer to put on the label what is called
5 an expiration date, and that usually reads to the
6 effect "This is not to be used after ... " -- and that
7 will be October 20, perhaps. Now, that date is set
8 after experience and research has indicated that the
9 drug is certainly stable and maintains its full
10 potency up to that time and after that time it begins
11 to drop off. Of course, that does not mean that
12 on October 20 it is fine and on October 21 it is no
13 good. But you have to have a date somewhere and state
14 a date, so you state 18 months after manufacture
15 or 6 months, or depending upon the stability of the
16 product.

17
18 Now, there are a number of drugs in the
19 regulations here where an expiration date is required.
20 Now, in connection with drugs for which no expiration
21 date is required, we do and have made surveys of
22 drugstores at this time where our inspectors have
23 been instructed to look for old stock and bring it
24 into the laboratory for checking. We have done a number
25 of surveys of this kind and have not only brought
26 it to the attention of the druggist, but brought it
27 to the attention of the manufacturer. Most manufacturers
28 have a recall system or some system where they don't
29 want drugs of their kind on the market when they
30 are obviously no good or have deteriorated. So they



1 have some kind of recall system. But we are on the
2 lookout for drugs which have dropped off in potency,
3 partly because the shelf life has been exceeded.

4 This again is a difficult problem, because
5 there may be many, many that we haven't tested.
6 We have tested a good many. Every drug, I presume,
7 has its own shelf life, and the manufacturers, I have
8 been told, keep on their shelves samples of these
9 drugs which they test from time to time under ordinary
10 storage conditions and therefore eventually give a
11 very good picture of the stability of their own products.

12 I don't think I can add any more, except
13 this: first of all, that the expiration date that
14 we know a drug is liable to deteriorate, and spot-checking
15 of such types of drugs.

16 THE CHAIRMAN: Dr. Morrell, it follows,
17 for course, that there is an economic or dollar loss
18 where obsolence exists.

19 DR. MORRELL: Yes.

20 THE CHAIRMAN: Someone has to bear that loss.

21 DR. MORRELL: Yes.

22 THE CHAIRMAN: And in endeavouring to protect
23 the public interest have you run into any difficulty
24 with manufacturers or retailers in getting these goods
25 off the shelf?

26 DR. MORRELL: No. I don't know who bears
27 the loss in the long run; that isn't my business.
28 Sometimes it is passed around to the manufacturer
29 and sometimes the manufacturer says it isn't his fault.
30



1 But we have not many arguments, Mr. Rowntree, with
2 people where we can say it is sub-potent. I have
3 yet to hear a serious argument.
4

5 THE CHAIRMAN: Would you have any information
6 as to whether the manufacturers check their products
7 for obsolescence in the hands of the retailer?
8

9 DR. MORRELL: Yes. I happen to know they
10 do in the case of vitamin products because we have
11 studied that. We know that they do in that case.
12

13 MR. LAVERGNE: Is it an offense if you put
14 a date on that this is not to be used after a certain
15 date and it is sold after that date? Is it an offense?
16

17 DR. MORRELL: No, it is not an offense.
18

19 MR. BRYDEN: It is just for the information
20 of the purchaser.
21

22 DR. MORRELL: For the purchaser.
23

24 MR. LAVERGNE: There is no doubt that it is
25 the public who is going to pay. If there is a loss
26 where they have to take it back, whether the manufacturer
27 loses it, it eventually goes down to the purchaser
28 or the user who pays for that.
29

30 DR. MORRELL: This is a marketing problem
and not in my field. I suspect that if you went into
a drug store and the druggist handed you a package
which was clearly marked "Not to be used after October
21st", I doubt if you would buy it, and they are well
aware of that.

MR. LAVERGNE: I say that the cost of
that is passed on to the user. Someone pays that cost,



1 and you said it is not in your field, but we can only
2 assume that it is the buyer who is going to pay for it.

3 DR. MORRELL: The cost of everything is
4 passed on to the consumer.

5 MR. LAVERGNE: This is what we are trying
6 to solve.

7 MR. BRYDEN: In view of the fact that your
8 Directorate is pretty closely in touch with the importa-
9 tion of drugs into Canada, is it possible that you
10 may be able to make an estimate of what proportion of
11 the import of bulk products which are subject to further
12 processing and what proportion are finished products
13 to be sold as they are?

14 DR. MORRELL: Yes, I think I have an idea
15 that the majority, that is more than half, would be
16 bulk products for further processing.

17 MR. BRYDEN: Would the further processing
18 take the form of making it into tablet form and making
19 suitable for sale?

20 DR. MORRELL: My guess is that that would be
21 so.

22 MR. BRYDEN: Would you have any idea what
23 proportion of drugs are sold here and manufactured
24 here?

25 DR. MORRELL: Manufactured means a lot of
26 things. You take carbohydrates --

27 MR. BRYDEN: In other words, you know of some
28 manufacturing here.

29 DR. MORRELL: Yes, it is a manufacturing
30



1 process, and if a tablet is made in Canada it is
2 partly manufactured here. I am sure at later dates
3 you will have people who will answer that question
4 better than I can.

5 MR. WREN: I heard you classify liquor
6 as one of the tranquillizers under the administration of
7 your Act. What would you classify alcoholic beverages
8 as? Food or drug?

9 DR. MORRELL: Food.

10 MR. WREN: Because I am particularly concerned
11 with some of these concoctions that the Liquor Control
12 Board sell in Ontario, these cheap wines particularly.
13 Do you ever take samples from the liquor store shelves
14 and have a look at some of that mau-mau brew that they
15 put out? I saw an example where it took a dogcatcher and
16 the Police Department and the Fire Department to
17 subdue a fellow.

18 DR. MORRELL: We have a laboratory in Ottawa
19 which is called the Alcoholic Beverages and Cosmetic
20 Section, and they do examine alcoholic beverages.

21 MR. TROTTER: Mr. Chairman, I would like to
22 ask Dr. Morrell a couple of questions having regard to
23 the manufacture of drugs outside of this country.
24 My understanding is that you are allowed by certain
25 countries or certain factories overseas to inspect
26 their plant. Is that correct?

27 DR. MORRELL: Yes, in the case of the licensed
28 plants we are allowed, because they must allow us, and
29 in the case of the unlicensed plants in certain cases
30



1 we are allowed to, yes.

2 MR. TROTTER: Can you give us any indication
3 if the standards are higher in those countries?

4 DR. MORRELL: Well, Europe is many countries.
5 In some countries they are as high, in other countries
6 they are not.

7 MR. TROTTER: We have heard about the
8 importation of drugs from Italy. What standards would
9 Italy have?

10 DR. MORRELL: A variety of standards, from
11 very good to poor.

12 MR. TROTTER: Do you have as much difficulty
13 -- or I should put it this way: do many occasions
14 arise when you check drugs from Italy?

15 DR. MORRELL: A number of occasions have
16 arisen in the last few years, particularly for the
17 examination of drugs which originate in Italy. Some
18 were in the form -- were in bulk, you might say,
19 and others were in finished pharmaceutical form.

20 MR. TROTTER: In recent years, has there
21 been an increase of drugs from Italy coming into this
22 country?

23 DR. MORRELL: Yes, I think so.

24 MR. TROTTER: Has there been a great increase?

25 DR. MORRELL: Well, I can remember the time
26 when there were not any that I knew of. There must have
27 been very, very few. Now, there are quite a few. But
28 whether it forms any significant portion of the total sales,
29 I am not aware. If you had one lot 20 years ago, there
30 might be a hundred lots today but still not any particular



significance in the total picture in Canada.

1 MR. TROTTER: Would it be correct to say,
2 Doctor, that the drug plants in Italy have the lowest
3 standards in Europe?

4 DR. MORRELL: Well, we haven't been to all
5 countries. No, I couldn't say that they have the
6 lowest standard in Europe because I don't know to begin
7 with. I can only say that some of them are not at all
8 good and others are excellent.

9 MR. TROTTER: Have you any idea how many
10 plants in Italy your men check?

11 DR. MORRELL: You are asking how many export --

12 MR. TROTTER: How many plants that produce
13 drugs in Italy that your men would be over there to
14 check?

15 DR. MORRELL: Well, I do know how many our man
16 checked, and he checked them because of the information we
17 received and had that they were exporting to Canada.
18 I think there were six.

19 MR. TROTTER: And of those six would any of
20 them be refused the right to export drugs to Canada?

21 DR. MORRELL: We couldn't refuse them the right
22 to export; that would be their own country. We could
23 refuse entry of batches of drugs from those countries
24 if we find that they are not up to standard or other-
25 wise in violation of the law. I don't think I would
26 have the right to say that we won't accept any drug
27 from Manufacturer X, we won't even examine, we just won't
28 accept -- I don't think I would have the right to say
29 that.
30

---(Page 958 follows.)



1 All I would do is examine every batch of
2 Manufacturer X, and those that meet the standards we
3 would allow them, and those that don't meet standards,
4 we refuse.

5 MR. TROTTER: From your experience, would
6 you say drugs that are imported by Canada from Italy
7 are as good or close to being as good as what we have,
8 what we produce here in Canada?

9 DR. MORRELL: Well, there are an awful lot of
10 drugs. Drugs of a certain class I have found --
11 some of them that I think have been quite good. At
12 least the samples we examined. Lots have been imported.
13 We have had difficulty with some. Perhaps it depends
14 on the difficulty in manufacturing a particular drug,
15 it causes it to show up in some particular drugs. I have
16 never sat down to divide the drugs by country, and the
17 results that we have obtained. There are too many
18 complicating factors to do that.

19 A drug has been imported in bulk from
20 Italy and may be messed up here by the man who puts it
21 in pharmaceutical form. Likewise, from the United States
22 that could happen too. The bulk product may have been
23 all right, but the pharmaceutical form was not. I don't
24 know how you would classify that particular drug,
25 partly manufactured in Canada and partly manufactured
26 abroad. I have never done this. I don't know that it
27 would be very profitable to do so.

28 MR. TROTTER: There is one final question in
29 my mind on the same line, Dr. Morrell: would it be
30



1 proper to say that the drugs imported by Canada from
2 Italy are of a good standard?

3 DR. MORRELL: I think they are all of
4 reasonable quality, yes. From Italy, you said?

5 MR. PRICE: Are any drugs imported from
6 Mexico?

7 DR. MORRELL: I don't think so.

8 MR. PRICE: Have any of your inspectors ever
9 inspected any plant manufacturing drugs in Mexico?

10 DR. MORRELL: No, only me. I happened to be
11 in Mexico City on a job once, and I did go to one
12 plant there, but certainly not from an idea of inspecting
13 them for sale in Canada. Just to see how they did it.

14 MR. WREN: Any from Cuba?

15 THE CHAIRMAN: What about South America?

16 DR. MORRELL: No, we have no drugs imported
17 from South America that I know of.

18 THE CHAIRMAN: Any other questions, gentlemen?
19 Well, Dr. Morrell, would you do this for the Committee?
20 Would you take a message to your Minister and express
21 our thanks to him for the courtesy of his Department
22 in making it possible for you to be here, and express
23 our thanks for that co-operation. Secondly, speaking
24 to you directly, please accept our personal thanks
25 to you for coming here and rendering the assistance
26 you have. It is much appreciated.

27 DR. MORRELL: Thank you, Mr. Rowntree.

28 THE CHAIRMAN: Now, tomorrow, Mr. Gadsby?

29 THE SECRETARY: 10.00 a.m. Dr. Ferguson of
30



1 Connaught Laboratories.

2 THE CHAIRMAN: Do you expect that will be a
3 long hearing or a short one?
4

5 THE SECRETARY: Short, I would say it would
6 not be any more than two hours.

7 THE CHAIRMAN: Very well, 10.00 o'clock
8 in the morning. We are adjourned.

9 ---Adjournment.
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